

041538 JAN 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02109

1- FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH ESTIMATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Esther May Clifford								1-10-87		1-10-87		1-10-87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. UNDER 1 YR.		8. UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	1-23-07		79 YRS.						Prince George's		Prince George's		MD.	
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13. CITIZEN OF WHAT COUNTRY?		14. MARRIED		15. NEVER MARRIED		16. WIDOWED		17. DIVORCED		18. HOUSEWIFE		19. HOME	
Washington DC		USA										Housewife		Home	
20. CITY OR TOWN OF DEATH		21. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		22. USUAL RESIDENCE (TYPE OF WORK)		23. KIND OF BUSINESS OR INDUSTRY		24. INSIDE CITY LIMITS?		25. STREET ADDRESS		26. INSIDE CITY LIMITS?		27. STREET ADDRESS	
Capital Hgts.		2031 Brooks Drive 423		Housewife		Home		YES		2031 Brooks Drive #423		YES		2031 Brooks Drive #423	
28. FATHER'S NAME		29. MOTHER'S MAIDEN NAME		30. WAS DECEASED EVER IN U.S. ARMED FORCES?		31. SOCIAL SECURITY NO.		32. INFORMANT		33. ADDRESS		34. LILLIAN I CHRISTENSEN		35. 5903 WHITE CT	
John A Many		Irene L Crutchet		No		578 09 0193		Lillian I Christensen		5903 White Ct					
36. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		37. PART I DEATH WAS CAUSED BY:		38. IMMEDIATE CAUSE (a)		39. DUE TO, OR AS A CONSEQUENCE OF		40. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		41. DUE TO, OR AS A CONSEQUENCE OF		42. DUE TO, OR AS A CONSEQUENCE OF		43. DUE TO, OR AS A CONSEQUENCE OF	
Hypertensive Cardiovascular disease															
44. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		45. DATE OF OPERATION		46. CONDITION FOR WHICH OPERATION WAS PERFORMED?		47. AUTOPSY?		48. YES		49. NO		50. YES		51. NO	
52. EXTERNAL CAUSE WAS		53. TIME OF INJURY		54. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		55. UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		56. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		57. LOCATION		58. CITY OR TOWN		59. COUNTY	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. WHILE AT WORK		21h. NOT WHILE AT WORK		21i. CITY OR TOWN		21j. COUNTY		21k. STATE	
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02710
REG. NO.

1. STATE REGISTRAR 10-19-87		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
DECEASED NAME (TYPE OR PRINT) Andrew Coakley		11		11	87	5 ⁰⁰	P.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
		MONTH DAY YEAR 12 05 12		74 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.			
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leeland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pharmacist		12b. KIND OF BUSINESS OR INDUSTRY private		
13a. STATE Md		13b. COUNTY Prince George	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4412 Tonquil St. 20705	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph M Coakley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Batzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-05-9013		17. INFORMANT ADDRESS Kathleen Coakley same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease 7 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Amyotrophic Lateral Sclerosis, Aspiration Pneumonia							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1987, to 1/11, 1987, that (I) (we) last saw the deceased alive on 1/11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul A. DeVore M.D.				DEGREE M.D.		22c. DATE SIGNED 1/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. DEVORE M.D.				22e. ADDRESS 9203 Queensbury Rd Hyattsville Md 20781			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George Md	
24. FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd Beltsville Md 20705				25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Ludlow	

3

18a, 21b, -22a, G-624, 2/5/87 STATE OF MARYLAND
 1- STATE REGISTRAR FOR by Med. Ex., /Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02/11
 REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST
 Michael Joseph Coffey
 2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR 2b HOUR
 1 9 19 87 M
 3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS) LAST BIRTHDAY 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2d HOUR
 MALE BLACK JUNE 21, 1955 31 YRS. MONTHS DAYS HOURS MIN. 1 9 19 87 10:40 a M
 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH
 WASH., D.C. U.S.A. WIDOWED ☐ DIVORCED ☐ Prince George's County, MD.
 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
 Seat Pleasant 7421 Crane Place NONE NONE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS
 MARYLAND Prince George's County CLINTON YES ☒ NO ☐ 12514 CAMBLETON DRIVE
 14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
 CHARLES B. COFFER, SR. Pearl Campbell
 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
 No (IF YES, GIVE WAR OR DATES) CHARLES COFFER - 12514 CAMBLETON DRIVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1 DEATH WAS CAUSED BY: intonation.)
 IMMEDIATE CAUSE (a) Bronchopneumonia complicating narcotic-
 DUE TO, OR AS A CONSEQUENCE OF
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)
 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION
 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐
 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 9 19 87 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
 21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home 21f. LOCATION Prince George's, 7421 Crane Place, Seat Pleasant, Md.
 22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒.

ACTUAL SIGNATURE TITLE (SPECIFY) DATE SIGNED
 11/10/87
 EXAMINER'S NAME Ann M. Dixon, M.D. ADDRESS 111 Penn St. Balto.MD.
 (TYPE OR PRINT)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
 BURIAL JAN 15, 1987 HARMONY PARK SUTHLAND PG MARYLAND
 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
 ALEXANDER POPE 2617 PA AVE SE DC JAN 13 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL AFTER ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMIT TO DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02712

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Eleanor Eddins Cole
2a. DATE OF DEATH MONTH DAY YEAR
January 8, 1987
2b. HOUR
1:30a

3. SEX
Female
4. RACE
Caucasian
5. DATE OF BIRTH
April 3, 1917
6. AGE (IN YEARS (LAST BIRTHDAY))
69
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia
7b. CITIZEN OF WHAT COUNTRY?
U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD

10. CITY OR TOWN OF DEATH
Hyattsville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3106 Kimberly Rd.,
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Person
12b. KIND OF BUSINESS OR INDUSTRY
Hugh T. Peck, Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland
13b. COUNTY
P.G.
13c. CITY OR TOWN
Hyattsville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE
3106 Kimberly Road, 20782

14. FATHER'S NAME FIRST MIDDLE LAST
Stanley Eddins
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maude G. (Unavailable)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No
16b. SOCIAL SECURITY NO.
579-07-9963
17. INFORMANT ADDRESS
Merle A. Cole, Husband, Same as line 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiac arrest secondary to arrhythmia**
Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b) **Arteriosclerotic cardiovascular disease**
Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Diabetes Mellitus, Hypertension, Obesity

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **September 30, 1977** to **January 8, 1987**, that (I) (we) last saw the deceased alive on **December 31, 1986**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. **Medical examiner notified**

22b. SIGNATURE **Carl J. Houmann** DEGREE
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED
1/8/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl J. Houmann, M.D.
22e. ADDRESS
4404 Queensbury Rd., Riverdale, Md. 20737

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation
23b. DATE
1-9-1987
23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory Alexandria, Virginia
23d. LOCATION CITY OR TOWN COUNTY

24. FUNERAL DIRECTOR NAME ADDRESS
Francis Gasch's Sons, P.A. 4739 Baltimore Ave., Hyattsville, Md. 20781
25a. DATE REC'D BY REGISTRAR
Jan 13 1987
25b. REGISTRAR'S SIGNATURE
Julia S. [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes" or "no", the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 / 1 3
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jane		MIDDLE W.		LAST COLE		2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 10:30 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 11, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P. G. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Pr. George's		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9115-R Blues Alley 20707	
14. FATHER'S NAME FIRST MIDDLE LAST George				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loryma White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS Patricia J. Houck 3402 Northshire Lane Bowie, MD 20716					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>emphysema</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>87</u> , to <u>1/19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Riad Dakheel M.D.</u>				DEGREE M.D.				22c. DATE SIGNED JAN 19, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Riad Dakheel, M. D.				22e. ADDRESS Suite 121 14300 Gallant Fox Lane Bowie, MD 20715					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JAN 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montgomery, MD			
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>			

12:30 PM January 15, 1961

Dear Mr. [Name]
I am writing to you regarding the [Topic] of [Subject].
I have reviewed the [Document] and [Information] and [Data].
I am pleased to [State] that [Result] is [Status].
I am sure that [Conclusion] will be [Outcome].

I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].

I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].

I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].

I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].
I am sure that [Conclusion] will be [Outcome].

041677 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 0 2 / 1 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ditamos Thomas COLLINS						2a. DATE OF DEATH MONTH DAY YEAR January 14, 1987				2b. HOUR 4:32AM _M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 7 MONTH 17 DAY 1982		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7647 Allendale Dr. 20785			
14. FATHER'S NAME FIRST MIDDLE LAST Amos Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luticia Stevens		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1944-1945 579-076-981		17. INFORMANT Barbara A. Hodge 7605 Barlow Rd. Palmer Park, Md. 20785			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SQUAMOUS CELL CARCINOMA-PYLAIFORM SINUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSION, HISTIOSARCOMA Right Thigh</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>86</u> , to <u>1/13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arvind M. Mehta MD								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arvind Mehta						22e. ADDRESS 7100 Balt. Ave. 509 College Park, Md. 20740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-19-1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS J.B. Jenkins F.H. 7474 Landover Rd. Landover, Md.						25a. DATE RECEIVED BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE Julia Dindon-Randall			

BP

RECEIVED
1974 OCT 10 10 10 AM
FBI - NEW YORK

408
100-153140

TO : DIRECTOR, FBI (100-153140)
FROM : SAC, NEW YORK (100-153140)
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

100-153140

043246 FEB 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 15

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY E LAST CONTEE			2a. DATE OF DEATH MONTH DAY YEAR 1 26 87		2b. HOUR 3:15PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 03 22 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Prince Geo	13c. CITY OR TOWN Upper Marl.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Hill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret C. Ford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 36 6571		17. INFORMANT ADDRESS Benjamin Johnson SAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>Dec 26 Jan 1987</u> to <u>Jan 26 Jan 1987</u> , that (1) (we) lost saw the deceased alive on <u>Jan 26 Jan 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) I (we) (did not) view the body after death.					
22b. SIGNATURE <u>René E. Grace MD</u>		22c. DATE SIGNED <u>27 Jan 87</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) René E. Grace MD	
22e. ADDRESS Clinton, MD		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/'87		23c. NAME OF CEMETERY OR CREMATORY Myers UMC Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Croom, P.G., Md.		23e. DATE REC'D. BY REGISTRAR FEB 6 - 1987			
24. FUNERAL DIRECTOR NAME Martell Adams, Aquasco, Md 20608		25a. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

W.C. 107-2240

1

041156

JAN 1987

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

02/10

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOAN S. COOKE			2a. DATE OF DEATH MONTH DAY YEAR 01 06 87		2b. HOUR 1:50 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 31, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston, Massa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collection Clerk		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL CENTER
13a. STATE Maryland	13b. COUNTY Pr Geo	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1307 Tiverton Place 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Walter B Somerby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dickie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-40-6446		17. INFORMANT ADDRESS Samuel Lee Cooke Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 1986 to Jan 6, 1987, that (I) (we) last saw the deceased alive on 1/6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry J. Hoff		DEGREE MD		22c. DATE SIGNED 1/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey S. Katzner		22e. ADDRESS 8926 Wesley Ave Rd Clinton MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 7Jan1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland, Md		25a. DATE RECD. BY REGISTRAR JAN 14 1987	
				25b. REGISTRAR'S SIGNATURE Julia Benson-Randall	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must also complete the coroner's pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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040209 JAN - 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 02717			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
JOHN Ernest COOKE			1		4		87		1.45am				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Caucasian		July 6, 1920		66		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				PRINCE GEORGES COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CLINTON MD		SOUTHERN MARYLAND HOSPITAL		Bus Driver		Transportation							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.				Pr. George		Brandywine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16307 Ashbox Rd., 20613			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John Ernest Cooke, Sr.				G. Gertrude Connick									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				218-12-7689		Phyllis M. Cooke, Same as line #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>ASHD</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 2</u> , 19 <u>87</u> , to <u>JAN 4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JAN 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>William Kent Furst</u>				MD				1-487					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
William K. Furst, M.D.				11701 Livingston Rd. Ft. Washington, Md. 20744									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		1-7-87		Immanuel Methodist		Brandywine, Pr. Geo. Md.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS													
Huntt Funeral Home, P.O. Box 156 Waldorf, Md. 20601				JAN 6 1987									

William J. Smith, M.D.
1901 Lincoln Ave. N.E.
Washington, D.C. 20002

Dr. J. W. Smith, M.D.
P.O. Box 152
Rt. 1, Smith, Pa. 15884

Postmaster: Please send no money orders to this address.
P.O. Box 152, Rt. 1, Smith, Pa. 15884

040713 JAN 14-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 18

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen V. Corcoran			2a. DATE OF DEATH MONTH DAY YEAR January 3, 1987		2b. HOUR 8:15AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 5 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4922 LaSalle Rd. 20780	
14. FATHER'S NAME FIRST MIDDLE LAST William P. Corcoran			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Twomey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Helen Gormley(Friend) 4820 45th St. N.W. D.C.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Flu Syndrome with Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 Mins. 10 Days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Chronic Brain Syndrome Secondary to Cerebral Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 10</u> , 19 <u>83</u> , to <u>Jan. 3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan. 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED Jan. 3, 1987	
22b. SIGNATURE <u>J. Neill Kennedy M.D.</u>				22d. ADDRESS 1145 19th St. N.W. Washington D.C.		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR DeVol Funeral Home <u>John F. DeVol</u>				25a. DATE RECD BY REGISTRAR JAN 8 1987			
				25b. REGISTRAR'S SIGNATURE <u>Julius Gordon</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the hospital physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this permit to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02119

REG. NO.

1 - FOR
STATE
REGISTRAR

2. DECEASED NAME (Type or print) John G. Coatts			2a. DATE OF DEATH MONTH DAY YEAR 1 1 87		2b. HOUR 135 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8 27 03	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Lanear	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Lanear Beltsville Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor Corp.	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD	13b. COUNTY PG	13c. CITY OR TOWN Lanear	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3415 Weyman South 20707	
14. FATHER'S NAME FIRST MIDDLE LAST David Coatts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winifred Ross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 129-03-4102	17. INFORMANT Jean Fowen 20794 8700 Pine Tree Rd Jessand		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> Uremia DUE TO, OR AS A CONSEQUENCE OF (b) <u>terminal renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Chronic renal failure</u>					
19a. DATE OF OPERATION 12/12/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/12/84 3415 Weyman South PG MD	
22. I certify that (1) (this hospital) attended the deceased from <u>12-31-84</u> to <u>12-31-84</u> , that (1) (we) lost <u>12-31-84</u> saw the deceased alive on <u>12-31-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and) (not) view the body after death.					
22a. SIGNATURE Daniel L. Maeller		DEGREE M.D.		22c. DATE SIGNED 1/1/87	
22b. PHYSICIAN'S NAME (Type or print) Daniel L. Maeller		22e. ADDRESS Lanear Beltsville Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1/4/87	23c. NAME OF CEMETERY OR CREMATORY BW Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Lanear PG MD	25a. DATE REC'D. BY REGISTRAR JAN 7 1987
24. FUNERAL DIRECTOR F.H. Inc.		ADDRESS 7601 Sand Spring Rd Lanear		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

BP

100-2-281010

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 27th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

Very truly yours,
J. H. [Signature]

15-18
141306 JAN 19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02120

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-11 1987										2b. HOUR M			
3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Barbara L. Covington										7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-11 1987										7d. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 10 42		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Cheverly P.G. MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? U.S.A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER				12b. KIND OF BUSINESS OR INDUSTRY											
11. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MD										13b. COUNTY Prince Georges		13c. CITY OR TOWN, INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 11341 Joyceton Dr.		13e. STREET ADDRESS 20772									
14. FATHER'S NAME FIRST MIDDLE LAST Roland Covington				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Thompson																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 120 346 364				17. INFORMANT Hilda Covington				ADDRESS 2537 BEDFORD AVE.											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--	--	--	--	--	--	--	--	--

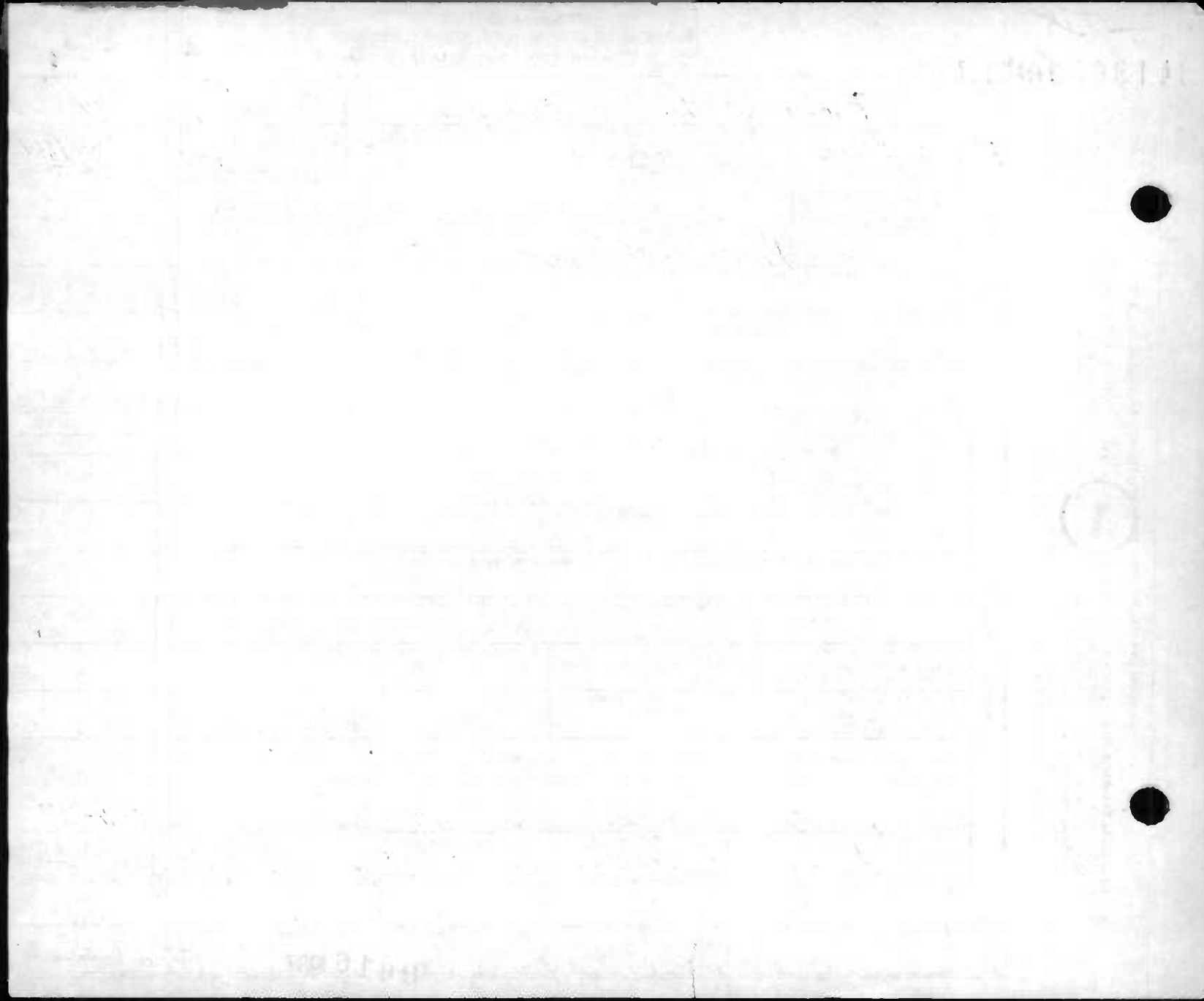
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>						TITLE (SPECIFY) M.D. <u>Deputy</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez MD</u>						ADDRESS <u>5009 Rayburn Ct. Camp Springs, Md</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-17-87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD	
24. FUNERAL DIRECTOR NAME March Funeral Home				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 16 1987	
				25b. REGISTRAR'S SIGNATURE <u>John Benson-Rudner</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 21

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alton I. Cox			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 8:00A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 16, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Oxon Hill	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5808 Woodland Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Foreman		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.
13a. STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Oxon Hill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5403 Woodland Blvd. 20745	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Cox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Cusick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-01-1482		17. INFORMANT Address 5403 Woodland Blvd. Oxon Hill, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19, 85</u> , to <u>1/19/87</u> , that (I) (we) lost saw the deceased alive on <u>1/15/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death.					
22b. SIGNATURE <u>Henry J. Kalas</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Henry J. Kalas</u>		22e. ADDRESS <u>8920 Woodland Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/22/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas		ADDRESS 6160 Oxon Hill Rd.		25a. DATE PRINTED BY REGISTRAR JAN 27 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02/22

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JUNIE E. CRAFT		2a. DATE OF DEATH MONTH DAY YEAR 01/25/87		2b. HOUR 8:20A M	
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 06/24/1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 77y	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles Milton Ross		15. MOTHER'S MAIDEN NAME Lily Virginia Polk		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-18-8112	
17. INFORMANT Richard Rau Sr. same as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <u>CERVICAL SPINE DISEASE PARAPLEGIA, DEBRITUS ULCERATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> <u>AUG</u> 19 <u>84</u> to <u>19</u> <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>E. S. MALHADO</u>		22c. DATE SIGNED <u>11/25/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMALHADO		22e. ADDRESS 321 PRINCE GEORGE ST		22f. DEGREE MD		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Jan 28, 1987		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Savage Howard Md	
24. FUNERAL DIRECTOR Donaldson Funeral Home P.A. Laurel, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 03 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

1. 240

040416 JAN 20

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02123

1. DECEASED NAME (TYPE OR PRINT) IRIDE M CROWDER			2a. DATE OF DEATH MONTH DAY YEAR 01 06 87			2b. HOUR 12:20 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Fitter		12b. KIND OF BUSINESS OR INDUSTRY Seamsstress Tailoring	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5108 Hagan Road 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Laurence			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarita DeJandre			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 579-07-4484			17. INFORMANT Audrey Sansbury 5108 Hagan Rd. Temple Hills, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>CORONARY ARTERY DISEASE</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CONGESTIVE HEART FAILURE</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 115 1987, to 116 1987, that (I) (we) last saw the deceased alive on 116 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE G. NACHNANI			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 116/87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. NACHNANI M.D.			22e. ADDRESS 8926 Woodyard Rd. Clinton, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/9/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			ADDRESS Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP

A.2.11

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505

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02724

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Hector CASADO Cruz Casado			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1 4 19 87			2b. HOUR 10:30 a.m.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 23, 1934	6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 1 7 19 87	2d. HOUR 10:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		

10. CITY OR TOWN OF DEATH Capitol Heights	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2110 Brooks Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
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13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Capitol Hghts	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 2110 Brooks Dr.		20747	

14. FATHER'S NAME FIRST MIDDLE LAST Damian Cruz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Justina Casado	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea 580-70-8917	17. INFORMANT ADDRESS Gloria Cruz, Calle 3 Bloque East 25 Primera Saneccion Villa, Carolina, P.R.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds of neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1 4 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2110 Brooks Drive, Capitol Hghts, P.G. CO, MD.

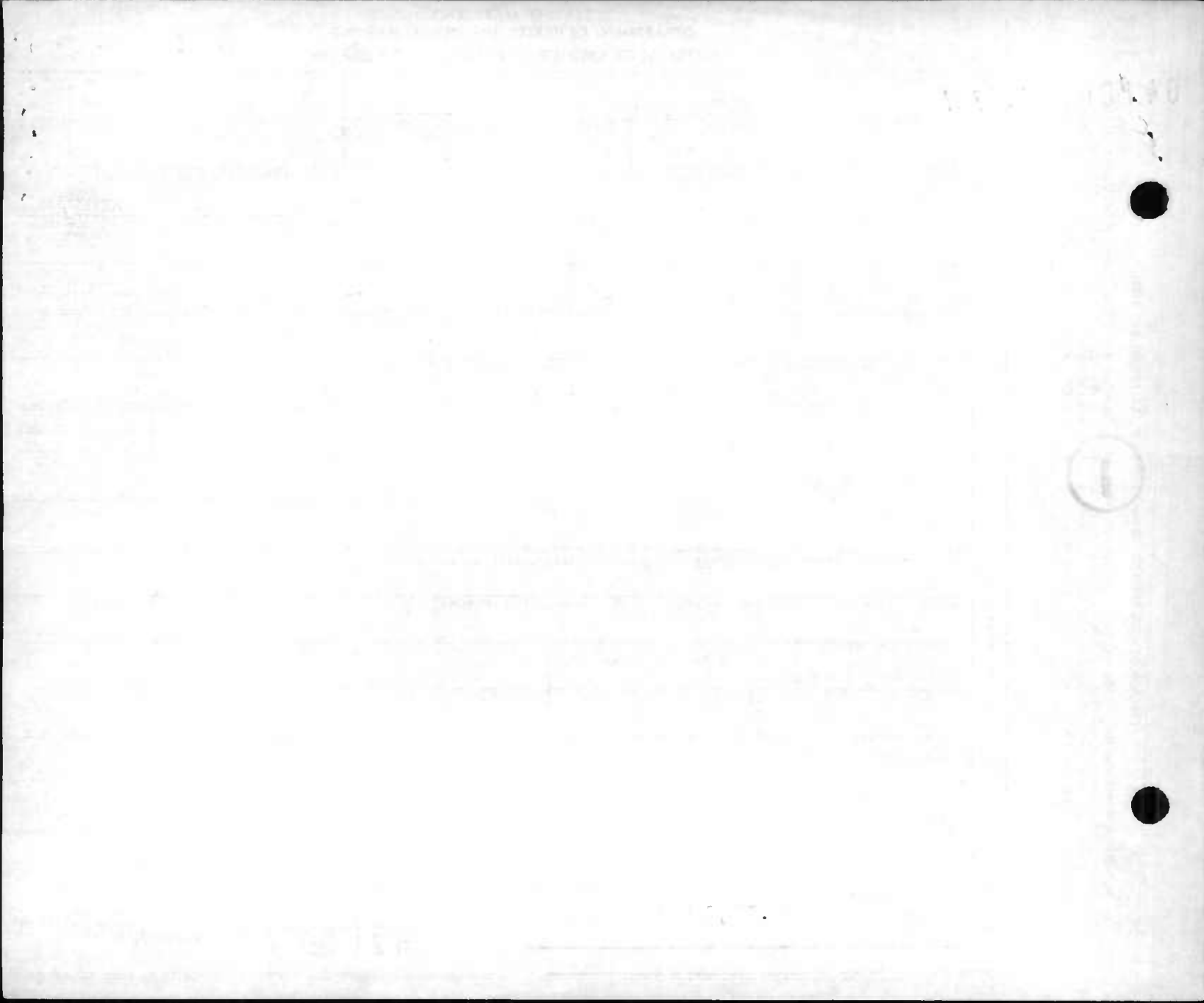
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER	DATE SIGNED 1/7/87
--	--	--	--------------------

ACTUAL SIGNATURE William M. Zane, M.D.	ADDRESS 111 Penn St. Balto.MD.
--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal XXXXXX	23b. DATE Jan. 13, 1987 XXXXXX	23c. NAME OF CEMETERY OR CREMATORY Anatomy Board Balto. Md.	23d. LOCATION CITY OR TOWN COUNTY STATE XXXXXX XXXXXXXXXX
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214		25. DATE RECEIVED BY JAN 21 1987	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

02 / 25

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR															
Edna		S.		Cunningham				DATE KNOWN OF DEATH		1/21		1987																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE KNOWN P. OF DEATH		MONTH		DAY		YEAR		24. HOUR											
Female		Black		Sep. 11, 1919		67 YRS.		MONTHS		DAYS		HOURS		MIN.		1/21		1987		7:50 P. M.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																			
North Carolina				USA								Prince George's County MD.																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Upper Marlboro				201 Herrington Drive								Beautician				Beauty Shoppe															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS															
Md.				PG				Largo				YES <input type="checkbox"/> NO <input type="checkbox"/>				201 Herrington Dr. 20783															
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME																							
FIRST								FIRST								MIDDLE								LAST							
Hayes								Swindell								Lucinda								Bryant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT								ADDRESS							
no								215-18-6155								Eugene Brown/nephew / 201 Herrington Dr															

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>	IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>	
	DUE TO, OR AS A CONSEQUENCE OF (b) _____	
	DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION	None			
	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
	None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE *John S. Rogers* M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1/22/87

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road
Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION COUNTY	STATE
Burial	1-27-87	Harmony Memorial Park	LANDOVER	Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Marshall's Funeral Home 4217 9th St NW: Washington, D.C.		1 JAN 27 1987 1:15 PM	[Signature]	

NOT TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE REASON FOR DELAY IN WRITING "PENDING" IN PENALTY ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES.

NOT TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF BURIAL, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR ANATOMY.

MEDICAL CERTIFICATION

07/84
25M

BP_____

DHMH - 17

(VR A15 ME (5))

JAN 27 1987

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041001 JAN-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02120

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Darlene Ann Custer			<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR			1 10 1987		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Female	Cauc.	12-23-1961	25	MONTHS	DAYS	1 10 1987	9PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		US				Prince George's County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Clinton		Southern Maryland Hospital				Driver		Auto
13a. STATE								
Maryland								
13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Charles			Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS		
Donald Wayne Custer			Margery A. Davis			34 West Drive/20601		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
no			579-84-7934		Ginger V. Custer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Cranio-cerebral trauma								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			2:10 P.M. 1 10 1987		Driver in auto/auto impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			road		Golden Beach Rd, Golden Beach, St. Mary's, MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			M.D. Deputy Chief			1/11/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			BALTO. MD.		
Ann M. Dixon, M.D.			111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		1-14-87		Trinity Memorial Gds.		Waldorf Charles Md.		
24. FUNERAL DIRECTOR			P. O. Box 156			25a. DATE REC'D. BY REGISTRAR		
Huntt Funeral Home			Waldorf, Md. 20601			25b. REGISTRAR'S SIGNATURE		
						JAN 14 1987		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

2001 001 1001 10

2001 001 1001 10



3

2001 001 1001 10

041879 JAN 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 2 /

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sara Miller D'Arago		2a. DATE OF DEATH MONTH DAY YEAR 1 12 87		2b. HOUR 2:15P _M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 26 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming - Ret.	
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Peter Prince George D'Arago		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della J. Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-9400		17. INFORMANT ADDRESS Charles R. Callis 9705 Potomac Drive, Ft. Washington, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic Brain Syndrome, post anoxic state</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Malignant, Delirious.</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/5</u> 19 <u>87</u> , to <u>1/12</u> 19 <u>87</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>1/12</u> 19 <u>87</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(was)</u> <u>(did not)</u> view the body after death.				
22b. SIGNATURE <u>E.Y. J. M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CYRUS V. PARSEY M.D.</u>		22e. ADDRESS <u>8700 Old Branch Ave. Clinton Md 20735</u>		
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <u>Burial</u>	23b. DATE <u>1/15/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland P.G. Maryland</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>GP. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</u>		25a. DATE REC'D BY REGISTRAR <u>JAN 27 1987</u>		
		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>		

05

... 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668,

#10, 11, G-626, 4/7/87, by Med. Ex. STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

043203 FEB 1987

REG. NO. 02128

FOR STATE REGISTRAR Gbj.

I. DECEASED NAME FIRST MIDDLE LAST
Juanita Davis

2a. DATE KNOWN OF DEATH MONTH DAY YEAR
XX 1-25 19 87

2b. HOUR
M

1. SEX F 4. RACE B 5. DATE OF BIRTH MONTH DAY YEAR
10 5 38 6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.
IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FL. 7b. CITIZEN OF WHAT COUNTRY? U. S. A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.

10. CITY OR TOWN OF DEATH Phila. 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Pa. 13b. COUNTY Phila. 13c. CITY OR TOWN Phila. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 1809 N. Franklin St. 19122

14. FATHER'S NAME FIRST MIDDLE LAST Eward Davis 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Harrison

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 177-32-7258 17. INFORMANT ADDRESS Samuel Evans 135 S. 18th. St. Phila. Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8151 IMMEDIATE CAUSE (a) Mechanical Compression of Chest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR
5:16 P.M. 1-25 19 87 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) passenger in auto which went over guardrail

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway 21f. LOCATION CITY OR TOWN COUNTY STATE
Rt. 95 to I495, Prince George's Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1-27-87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial 23b. DATE 2/7/87 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE
Philadelphia, Pa.

24. FUNERAL DIRECTOR NAME ADDRESS Powell F/H Inc. 2432-34 N. 27th. St. Phila. Pa. 25a. DATE REC'D. BY REGISTRAR FEB 3 1987 25b. REGISTRAR'S SIGNATURE [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



040656 JAN 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 29

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AURELIO VINCENZO DEL GALLO		2a. DATE OF DEATH MONTH DAY YEAR 1 8 87		2b. HOUR 2 A.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9-23-25		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Brentwood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Giovanni Del Gallo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Santina Tonelli			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-42-3964		17. INFORMANT ADDRESS Wanda Del Gallo, Same as Line #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFARCTION</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>X</u>					
19a. DATE OF OPERATION <u>X</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>X</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>X</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>X</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>X</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7-1987</u> to <u>1-8-1987</u> , that (I) (we) last saw the deceased alive on <u>1-8-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>ASIF S. QADRI</u>		DEGREE MD		22c. DATE SIGNED 1-8-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASIF S. QADRI		22e. ADDRESS 4700 BERWYN HOUSE RD, COLLEGE PK, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-10-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (CITY OR TOWN) Brentwood		COUNTY P.G., Md.		STATE	
24. FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 13 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Henderson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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040083 JAN 6 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02730

1. DECEASED NAME (TYPE OR PRINT) Robert Dent										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 1-5 19 87		2b. HOUR M 6:32 a.m.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 06 13 27 59		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 59		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-5 19 87		7d. HOUR M 6:32 a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10. CITY OR TOWN OF DEATH Landover				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7201 E. Lombard Street				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Painter				12b. KIND OF BUSINESS OR INDUSTRY Govt.	
13a. STATE Md. COUNTY Prince George's										13b. CITY OR TOWN Landover		13c. STREET ADDRESS 7201 E. Lombard St.	
14. FATHER'S NAME FIRST MIDDLE LAST Fred Dent				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magnolia Hendrix				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1947	
17. INFORMANT Bernice R. Dent										ADDRESS 7201 E. Lombard St.		City, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 615xxx 1-5 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot himself					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7201 E. Lombard St., Landover, Prince George's Co., Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 1-6-87	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 01-8-87		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Md.			
24. FUNERAL DIRECTOR J.B. Jenkins				25a. DATE REC'D. BY REGISTRAR JAN 6 1987				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

DIVISION OF VITAL RECORDS, 20 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 20 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

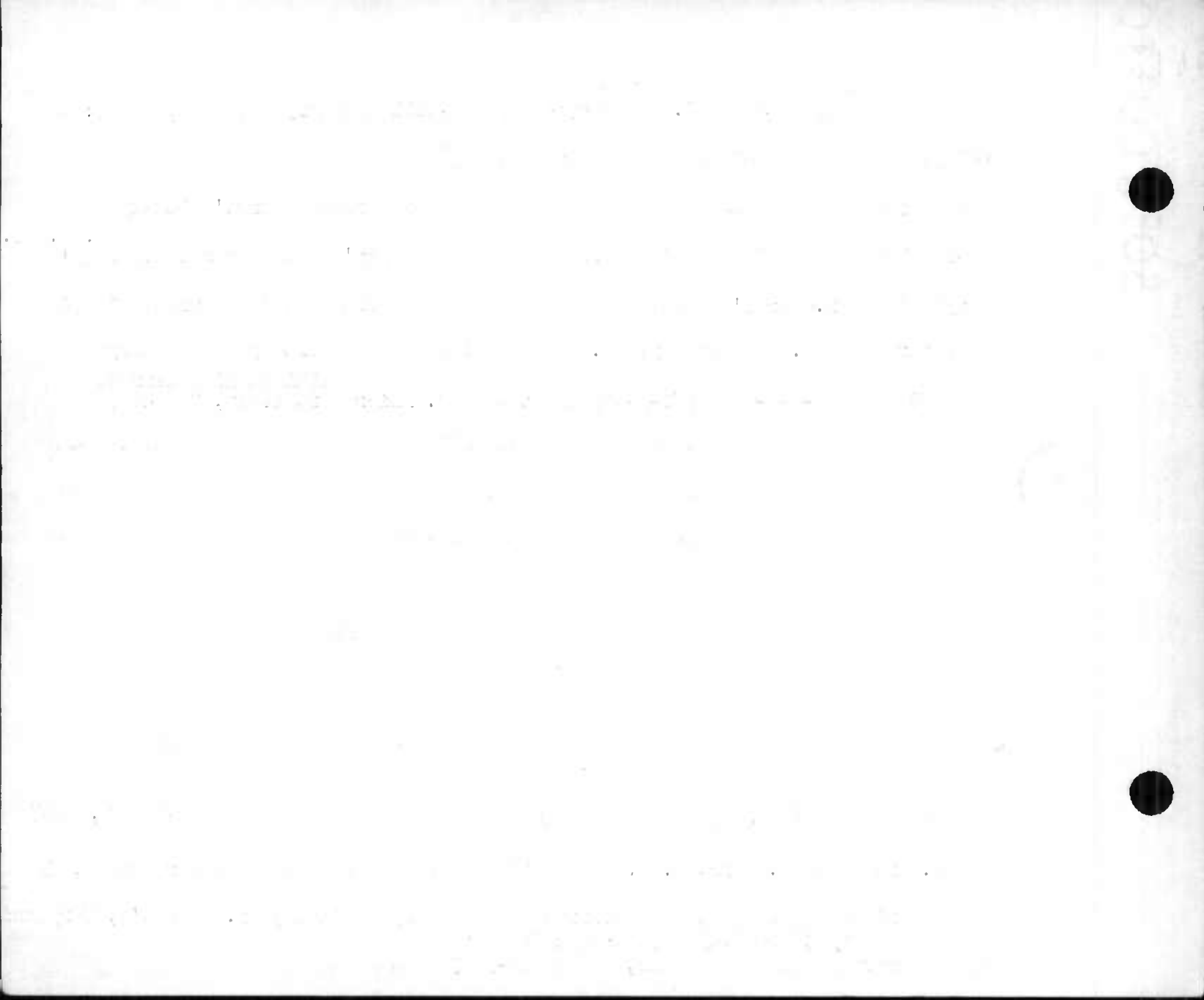
1. DECEASED NAME (TYPE OR PRINT) Peter P. Devaney, III			2a. DATE OF DEATH MONTH DAY YEAR January 11, 1987			2b. HOUR 7:00 AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8211 Canning Terrace			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ass't Chief Coordinator/Gov't		12b. KIND OF BUSINESS OR INDUSTRY P. G. Co.			
13a. STATE Maryland		13b. COUNTY Pr. George's		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8211 Canning Terrace 20770		
14. FATHER'S NAME FIRST MIDDLE LAST Peter P. Devaney, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Dorothy Duffy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - - -			16b. SOCIAL SECURITY NO. 578-34-2581	
17. INFORMANT ADDRESS 8211 Canning Terrace Greenbelt, MD 20770										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 months</u> <u>3 months</u> <u>3 months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-4</u> , 19 <u>86</u> , to <u>1-11</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frederick G. Barr</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED JAN 12, 1987				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Frederick G. Barr, M. D.						22e. ADDRESS 2101 Medical Park Drive Silver Spring, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JAN 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Pr. George's, Maryland				
24. FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <u>Li. F. J. J.</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02132

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME Lena River Disney		MONTH DAY YEAR 1-28 1987		AS	
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 5, 1886	6. AGE (IN YEARS) 100	7. IF UNDER 1 YR. MONTHS DAYS HOURS MINS.	8. IF UNDER 24 HRS. HOURS MINS.
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	10. CITIZEN OF WHAT COUNTRY? U.S.A.	11. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
13. CITY OR TOWN OF DEATH Clinton	14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Southern Maryland Hospital	15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		16. KIND OF BUSINESS OR INDUSTRY Own Home	
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland	18. STATE P.G.	19. CITY OR TOWN Temple Hills	20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21. STREET ADDRESS 2703 Keating Street 20748	
22. FATHER'S NAME William	23. MOTHER'S MAIDEN NAME Jane Keller	24. ADDRESS Marion Houser (Daughter) Same as #13			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? No		26. SOCIAL SECURITY NO. 216-82-6169		27. INFORMANT Marion Houser (Daughter) Same as #13	
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Left hip fracture with complications DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which give rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
29a. DATE OF OPERATION 1/2/87		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Left hip fracture		30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		31b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Legs gave way while walking + she fell.		32. LOCATION CITY OR TOWN COUNTY STATE Temple Hills Prince George's Md.	
33a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		33b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		33c. EDUCATION STREET CITY OR TOWN COUNTY STATE 2703 Keating Street SE, Temple Hills, Prince George's, Md.	
34. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
35. ACTUAL SIGNATURE Augusto P. Rodriguez		36. TITLE (SPECIFY) Deputy		37. DATE SIGNED 1-28-87	
38. EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		39. ADDRESS 5009 Rayburn Ct, Temple Hills, MD			
40a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	40b. DATE 02/02/87	40c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		40d. LOCATION CITY OR TOWN COUNTY STATE Fort Meade Anne Arundel Md.	
41. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		42a. DATE REC'D. BY REGISTRAR FEB 6 1987		42b. REGISTRAR'S SIGNATURE Julia Swisher-Rodriguez	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL WITHIN 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- STATE REGISTRAR										
1 DECEASED NAME (TYPE OR PRINT) George W. Dorsey					2a DATE OF DEATH MONTH DAY YEAR 1-10-87					
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 03 27 04		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		2b HOUR 6:40 PM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10 CITY OR TOWN OF DEATH Adelphi		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EEO Officer		12b KIND OF BUSINESS OR INDUSTRY Gen. Serv. Admin.		
13a STATE Maryland					13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George Jackson Dorsey					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amitie Lillian Nolan					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 157-18-9744		17 INFORMANT ADDRESS William R. Dorsey, 1009 Creethaven Dr, Silver Spring, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) END Stage Renal Failure										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from Jan 2 19 87, to Jan 10 19 87, that (I) (we) last saw the deceased alive on Jan 10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b SIGNATURE David Cromwell				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/11/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) David Cromwell				22e ADDRESS 831 University Blvd, Silver Spring, Md 20903						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1/15/87		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince George's, Md.				
24 FUNERAL DIRECTOR NAME McGILL FURNERAL SERVICE, INC.				ADDRESS 7400 GEORGIA AVE		DATE REC'D. BY REGISTRAR JAN 20 1987		25 REGISTRAR'S SIGNATURE		

BP

Male

Black

61

Pennsylvania

United States

x

Prince George's

Height

Presidential Woods

LED Officer

Gen. Serv. Admin.

Barryland

Montgomery

Silver Spring

x

1009 Greenhaven Drive 20002

George Jackson Dorsey

White Lillian Nolan

Silver Spring, Md.

No

157-18-0744 William R. Dorsey, 1009 Greenhaven Dr,



Trial

1/15/87

Fort Lincoln Cemetery, Prince George's, Md.

040128 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02134

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE OF DEATH			2d. HOUR			
DENISE L. DUGANS			1/ 1/ 1987			1/ 1/ 1987			1/ 1/ 1987			2:02 a m			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH									
FEMALE	WHITE	AUG. 15 1962	24 YRS.			Prince George's County, MD.									
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12. MARRIED			13. NEVER MARRIED			14. DIVORCED			
MARYLAND			U. S. A.			WIDOWED			NEVER MARRIED			DIVORCED			
15. CITY OR TOWN OF DEATH			16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			18. KIND OF BUSINESS OR INDUSTRY						
LAUREL			14900 Old Gunpowder Rd.			ASSEMBLY			SINGER						
19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
19a. STATE			19b. COUNTY			19c. CITY OR TOWN			19d. INSIDE CITY LIMITS?			19e. STREET ADDRESS			
MD			PRINCE GEORGES			BELTSVILLE			YES			4811 POWDERMILL RD. 20705			
20. FATHER'S NAME			21. MOTHER'S MAIDEN NAME			22. INFORMANT			23. ADDRESS						
ROLAND EDGAR DUGANS SR			PEGGY LEE RIDDLE			MARK HARPOLE			0350 SUNSET DR.			ELLICOTT CITY MD. 21043			
24. WAS DECEASED EVER IN U.S. ARMED FORCES?			25. SOCIAL SECURITY NO.			26. INFORMANT			27. ADDRESS						
NO			212-84-0758			MARK HARPOLE			0350 SUNSET DR.			ELLICOTT CITY MD. 21043			
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Thoraco-abdominal trauma															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
29a. DATE OF OPERATION			29b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						30. AUTOPSY?						
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
31a. EXTERNAL CAUSE WAS			31b. TIME OF INJURY			31c. HOW INJURY OCCURRED									
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			2 XX 1-1- 1987			Driver of auto/fixed object impact.									
32a. INJURY OCCURRED			32b. PLACE OF INJURY			32c. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>			STREET, FACTORY, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE									
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			road			14900 Old Gunpowder Rd. Prince George's, MD									
33. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
34. ACTUAL SIGNATURE			35. TITLE (SPECIFY)						36. DATE SIGNED						
Ann M. Dixon, M.D.			Deputy Chief						1/1/87						
37. EXAMINER'S NAME			38. ADDRESS												
(TYPE OR PRINT)			111 Penn St.												
39a. BURIAL, CREMATION, REMOVAL			39b. DATE			39c. NAME OF CEMETERY OR CREMATORY			39d. LOCATION			39e. COUNTY		39f. STATE	
BURIAL			5 JAN 87			MEADOWRIDGE MEM. PK.			ELKRIDGE			HOWARD		MD.	
40. FUNERAL DIRECTOR			41. ADDRESS			42. DATE REC'D. BY REGISTRAR			43. REGISTRAR'S SIGNATURE						
SLACK FUNERAL HOME			BOX 268 ELLICOTT CITY, MD. 21043			JAN 5 1987			Julia Dixon-Randall						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 2 of page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ELINOR DUNN</i>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>1 7 87 5^{PM}</i>				
3. SEX <i>Female</i>		4. RACE <i>CAC</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 8 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PD</i> MD.			
10. CITY OR TOWN OF DEATH <i>Adelphi</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Presidential Woods</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Adelphi</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1801 Metzert Rd. 20783</i>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>215-36-4518</i>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>5/16</i> 19 <i>85</i> to <i>1/21</i> 19 <i>87</i> , that (1) (we) lost sight of the deceased above on <i>9/17</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/7/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABRAHAM DABELA</i>				22e. ADDRESS <i>4404 Queensbury Rd. Riverdale MD 20737</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>1-7-87</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 12 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

BP

100-100000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRECISE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02130	
FOR item 1,5, film G626 1- STATE REGISTRAR 4-16-87 I.J.											
DECEASED NAME (TYPE OR PRINT) Daniel M. Duttweiler										7a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1-22 1987	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1935 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. 7c. DATE PRONOUNCED DEAD 1-22 1987										7b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver			12b. KIND OF BUSINESS OR INDUSTRY Trucking	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12816 10th Street 20715		
14. FATHER'S NAME FIRST MIDDLE LAST Leland Martin Duttweiler						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Hodge					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes						16b. SOCIAL SECURITY NO. 579-48-6059		17. INFORMANT ADDRESS Lois M. Lisko same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER DATE SIGNED 1-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan 27 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 4600 Annapolis Road Bowie, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE John Gordon-Rodner	

18527

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 0 2 / 3 1
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris J Eanes			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1987		2b. HOUR 11:50AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 8 1934		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Ft Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 3103 Bolivia Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager-Food		12b. KIND OF BUSINESS OR INDUSTRY Cafeteria
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13a. COUNTY 13a. CITY OR TOWN Maryland Pr Geo Ft Wash			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 3103 Bolivia Court 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Robert L Parnell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Mae Vanderlip			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 42 9372		17. INFORMANT ADDRESS Howard C Eanes Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Brain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Seizure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-17 19 86 to 10-24 19 86 , that (I) (we) lost saw the deceased alive on 10-24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE M.D.		22c. DATE SIGNED 1/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN T. ONG, MD.		22e. ADDRESS 6357 OXON HILL ROAD OXON HILL, MARYLAND 20745				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22Jan1987		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland Maryland		25a. DATE REGISTERED JAN 28 1987		
25b. PREPARATOR'S SIGNATURE [Signature]		25c. DATE OF PREPARATION JAN 28 1987				

04 1987 JAN 28 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02 / 38
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEAN EASON			2a. DATE OF DEATH MONTH DAY YEAR 01 01 87		2b. HOUR 6 50P M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5-13-33		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Glenarden		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Glenarden Parkway 7810 209A		
14. FATHER'S NAME Bruce		15. MOTHER'S MAIDEN NAME Patsy Faulcon		16. ADDRESS 7810 - Glenarden Parkway		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NOT KNOWN)		16b. SOCIAL SECURITY NO. NO 578-54-4463		17. INFORMANT Joseph Eason - Husband		
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MARKED CARDIAC HYPERTROPHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL EDEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS DAYS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY EMBOLI II PNEUMONITIS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE George Bone		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 1/2/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BONE		22e. ADDRESS 8601 GEORGE PALMER HWY				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-87		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland
24. FUNERAL DIRECTOR Lemuel R. Woodard		25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE Julia S. ...		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP _____

041915 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02 / 39
REG. NO.

2. DECEASED NAME (Type or print)		FIRST Effie		MIDDLE Mae		LAST Edfeldt		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A	
								January 20 1987		5:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
				March 1 1904		82 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
Maryland		USA									
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Prince George Hospital						12a. USUAL OCCUPATION (Type of work for most of working life) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13a. STATE Maryland 13b. COUNTY Pr George 13c. CITY OR TOWN Dist Hgts											
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS 13f. ZIP CODE 6204 Elmhurst Street 20747											
14. FATHER'S NAME William MIDDLE Farrall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wink							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578 30 7901				17. INFORMANT ADDRESS Baltimore Md Mildred E Rhoads 3908 Klausmier Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hour</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonitis</u> <u>1 week</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Interstitial Lung Disease</u> <u>months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/10 19 87</u> to <u>1/20 19 87</u> , that (I) (we) last saw the deceased alive on <u>1/19 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David M Goldman</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-20-87			
22d. PHYSICIAN'S NAME (Type or print) David M Goldman		22e. ADDRESS 7500 Hanover Pkwy Greenbelt Md 20770									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 23Jan1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		Funeral Home Suitland Maryland		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia S. S. S.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02 / 40
REG. NO.1. FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) Valda C. ELY			2a. DATE OF DEATH January 9, 1987			2b. HOUR 10:54P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 24, 1917 MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. STATE Florida			13b. COUNTY Polk		13c. CITY OR TOWN Winterhaven		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 40 Lake Charlotte Drive 33880		
14. FATHER'S NAME FIRST MIDDLE LAST Chester Berry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Bradshaw			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 015-19-9109	
17. INFORMANT Robert A. Trotter, Pepperell, MA 01463			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Liver Cirrhosis with esophageal varices</u> (c) <u>infectious hepatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>chronic obstructive lung disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>87</u> to <u>1/9</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Riad Dakheel</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Riad Dakheel</u>			22e. ADDRESS <u>14300 Gallant Fox Ln, Bowie, MD 20715</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY Pepperell Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Pepperell, Massachusetts			
24. FUNERAL DIRECTOR NAME Hamilton Funeral Home			ADDRESS P. O. Box 167, Pepperell, MA 01463			25a. DATE RECD. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE <u>Nita Darden-Pandey</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official certifier, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

CONFIDENTIAL
U.S. GOVERNMENT

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CONFIDENTIAL



CONFIDENTIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

02741

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James David Emmell			2a. DATE OF DEATH MONTH DAY YEAR 1 24 87			2b. HOUR 5:30 A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Worker		12b. KIND OF BUSINESS OR INDUSTRY W.S.S. C.			
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6700 Belcrest Rd. (20782)		
14. FATHER'S NAME FIRST MIDDLE LAST Chester N. Emmell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret = Mc Kenna			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 578 34 8294	
17. INFORMANT Son			ADDRESS 5904 Halsey Rd. Rockville Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic obstructive pulmonary disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/24, 19 87, to 1/24, 19 87, that (I) (we) last saw the deceased alive on 1/24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert A. DeVol</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Leland Hospital-Riverdale Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-28-87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring-Montgomery-Md.			
24. FUNERAL DIRECTOR NAME Robert A. DeVol			ADDRESS 2222 Wisc Ave. Washington D.C.			25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE <u>John P. ...</u>			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02742

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		2b. HOUR	
Thomas Lewis England								1-24-87					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	May 7, 1925		61 YRS.						1-24-87			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Kentucky		U.S.A.		WIDOWED		DIVORCED		X Prince George					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Dorsey Rd		3718 34th Street		Brick Mason		Self Employed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Prince George		Mt. Rainier		XX NO		3718 34th Street				20712	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John Gilbert England		Manevia Jane Hulin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		9/28/50-10/2/52		225-28-5481		Thomas L. England, Leesburg, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Squamous Carcinoma of lung with metastases													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide	
Homicide		Undetermined manner											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Augusto P. Rodriguez		Deputy		1-24-87									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Jan. 28, 1987		Quantico National Cemetery		Prince William Virginia							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lee Funeral Home		8521 Sudley Road, Manassas, Va.		FEB 09 1987		John Davidson							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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(VR A15, ME (15))

041540 JAN 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02743
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joanne R. Feffer			2a. DATE OF DEATH MONTH DAY YEAR Jan 15 1987			2b. HOUR 3:40 PM					
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 31 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltville Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3451 Andrew Ct. #201 20707		
14. FATHER'S NAME FIRST MIDDLE LAST F. Frederick Ruzicka			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Kasper								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 216-20-0923B		17. INFORMANT ADDRESS Philip Feffer same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>due to cerebral thrombosis</u> over severe metabolic alkalosis DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute respiratory carcinoma</u> acute bronchopneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>liver carcinoma</u> <u>uterine</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:40 P.M. 1-15-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 201 W. Preston St.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1-04-87</u> , 19 <u>87</u> , to <u>1-15-87</u> , that (I) (we) last saw the deceased alive on <u>1-04-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. J. C. Marone</u>			22c. DATE SIGNED 1-16-87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. J. C. Marone			22e. ADDRESS 3451 Andrew Ct. #201 Laurel, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/16/87		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Creamtory		23d. LOCATION Laurel P.G. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS 7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707					25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE Julia E. ...				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Item # 16a, Film G 624, 2/24/87 r

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 44

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE VIOLET FERRIN			2a. DATE OF DEATH MONTH DAY YEAR January 31 1987		2b. HOUR P 2:28 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20 1924		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 62 YRS		
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Ft. Washington		
14. FATHER'S NAME FIRST MIDDLE LAST Charles J. Zink		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet T. Sharpless		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWI & Korea		16b. SOCIAL SECURITY NO. 121-16-6207		17. INFORMANT ADDRESS 9804 Moreland St. Milton J. Ferrin Ft. Washington, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO OR AS A CONSEQUENCE OF (b) Spontaneous coronary vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 31 JANUARY 87 31 JANUARY 87		
22a. I certify that (b) (this hospital) attended the deceased from 31 JANUARY 87 to 31 JANUARY 87 , that (we) last saw the deceased alive on 31 JANUARY 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dean A. Lusardi				22c. DATE SIGNED 31 JANUARY *		
22e. ADDRESS DEAN A. LUSARDI 0-3				22d. NAME OF HOSPITAL MALCOLM GROW USAF MED CTR (MAC) ANDREWS AFB, WASHINGTON, D.C. 20331		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/4/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		
24. FUNERAL DIRECTOR NAME George P. Kalas		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland		25a. DATE REC'D. BY REGISTRAR EB 3 1987		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MARYLAND 21201

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Washington, D.C.

Medical Center

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 02145

1. DECEASED NAME (TYPE OR PRINT) First: <u>Joseph</u> Middle: <u>Leo</u> Last: <u>Fitzmaurice</u>			2a. DATE OF DEATH MONTH: <u>11</u> DAY: <u>13</u> YEAR: <u>87</u>		2b. HOUR <u>12 28 PM</u>
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH: <u>June</u> DAY: <u>12</u> YEAR: <u>1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.	IF UNDER 1 YEAR MONTHS: <u></u> DAYS: <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Prince Georges</u> MD.	
10. CITY OR TOWN OF DEATH <u>Greenbelt</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Greenbelt Convalescent Home</u>		12a. USUAL OCCUPATION (GIVE LIFE) <u>Administrative Law Judge</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
13a. STATE <u>Maryland</u>			13b. COUNTY <u>P.G.</u>	13c. CITY OR TOWN <u>Greenbelt</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First: <u>Owen</u> Middle: <u>Fitzmaurice</u> Last: <u>Fitzmaurice</u>			15. MOTHER'S MAIDEN NAME First: <u>Nora</u> Middle: <u>Buckley</u> Last: <u>Buckley</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-34-1344</u>		17. INFORMANT Name: <u>Mary M. Fitzmaurice</u> Address: <u>Same as line 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Seizure Disorder, Aspiration Pneumonia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17/86</u> to <u>1/3/87</u> that (I) (we) lost <u>saw the deceased alive on 12/17/86</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stuart Turkewitz</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/3/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart Turkewitz</u>		22e. ADDRESS <u>7500 Greenbelt Ctr. Dr. #430 Greenbelt, Md. 20770</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1-7-87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Mont., Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Francis Gasch's Sons, Pa.</u> <u>4739 Baltimore Ave., Hyattsville, Md. 20781</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rudman</u>

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then, with the State Dept. of Health and Mental Hygiene prior to burial, with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked as item (b) when any injury or disease event, the medical certificate is not valid.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02 / 46

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irene S. Floyd				2a. DATE OF DEATH MONTH DAY YEAR 1 12 87		2b. HOUR 6²⁶ A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 15 09		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Shockley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Miller		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 220-34-8654		17. INFORMANT (Daughter) Patricia F. Schultz		17. ADDRESS 4510 Holmehurst Way, West Mitchellville, Md. 20715			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiration and cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe chronic obstructive pulmonary disease with cor pulmonale years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Severe obstruction Hypertension Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>April</u> 19 <u>86</u> to <u>January 12</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>January 11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Byrl D. Johnson</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/12/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Byrl D. Johnson, M.D.		22e. ADDRESS 4404 Queensbury Road, Riverdale, Md. 20737					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/15/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL HOME Francis Gersch's Sons Funeral Home, P.A.				25a. DATE REC'D. BY REGISTRAR 19 1987			
24. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781				25b. REGISTRAR'S SIGNATURE <u>Julia Tendon-Rudner</u>			

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040675 JAN 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

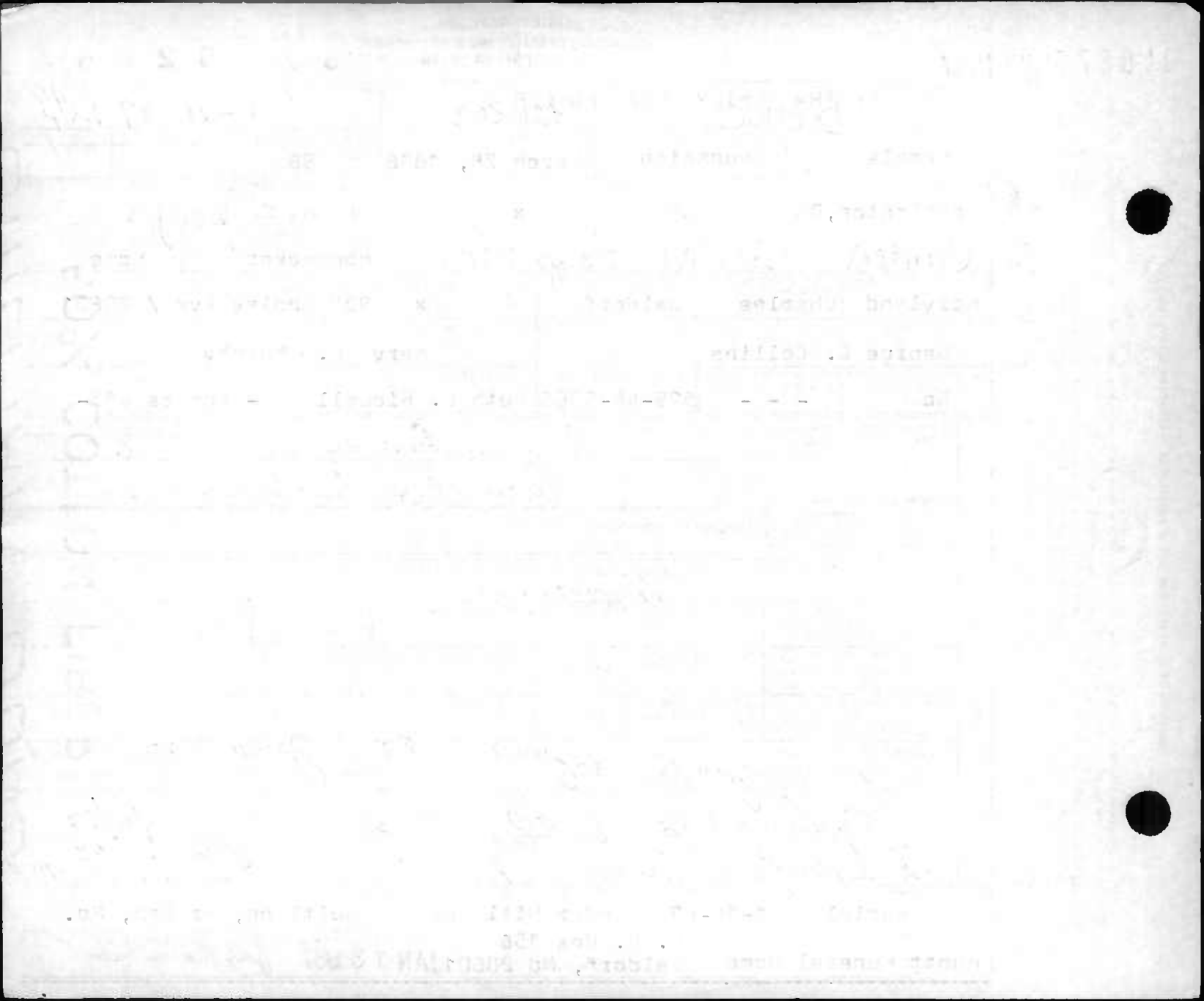
87 REG. NO. 02747

1. DECEASED NAME (TYPE OR PRINT) BERTHA EMILY COX FOWLER <i>Bertha Fowler</i>				2a. DATE OF DEATH MONTH DAY YEAR 1-11-87				2b. HOUR 1240 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hosp. Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 930 Copley Ave / 20601	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Collins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-5366		17. INFORMANT ADDRESS Ruth L. Kidwell - same as #13-					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) 10 years (c) 6 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1987 to Jan 11, 1987 that (I) (we) lost saw the deceased alive on Jan 10, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Sanford Young MD				DEGREE MD		22c. DATE SIGNED 1/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sanford Young				22e. ADDRESS 17701 Livingston RD IDI IT WASH			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-14-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr Geo, Md.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home				P. O. Box 156 ADDRESS Waldorf, Md 20601		25a. DATE REC'D. BY REGISTRAR JAN 13 1987	
				25b. REGISTRAR'S SIGNATURE John E. Anderson			



042267 JAN 25 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02748
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Estelle V Fowler			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 7:45 am		
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 3 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St MARYLAND Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles D Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Hayes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-60-6178	
17. INFORMANT Olen F Thompson		18. ADDRESS 6316 Briley Place Bethesda Md 20816					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from Oct. 27 , 19 86 , to Jan. 19 , 19 87 , that (I) (we) last saw the deceased alive on Jan 19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William Oetgen</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan. 20, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Oetgen M.D.				22e. ADDRESS 3611 Branch Avenue Hillcrest Hgts Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-87		23c. NAME OF CEMETERY OR CREMATORY Cedar HILL Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please register carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

0-55261-10



100% COTTON
FINE
PINK



043106 FEB 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02149

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Andrew Franklin, Sr.								1-25-87									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	Sept. 28, 1908		78 YRS.						1-25-87							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Georgia		United States		WIDOWED		DIVORCED		Prince George's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
District Heights		1817 Tanow Place		Food Serv. Employee		Food Service											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE (CITY LIMITS?)		13e. STREET ADDRESS									
Maryland		Pr. George's		District Hgts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1817 Tanow Place									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Benjamin Franklin		Alice Rivers															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		577-05-6680		Treny B. Franklin, 1817 Tanow Pl, District Heights, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Sudden atherosclerotic cardiac rupture													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Augusto P. Rodriguez		Deputy		1-25-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		1/31/87		Harmony Memorial Park		Highland Park, Pr. Geo., Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
McGuire Funeral Service		7400 Georgia Ave. N.W.		FEB 4 1987													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

McGuire Funeral Service 7400 Georgia Ave. N.W.
Washington, D.C.

Harmony Memorial Park Highland Park, Pr. Geo., Md.

Burial

13/97

Benjamin Franklin
Terryland
T. George's District Hqts.
1817 Tanow Place
Food serv. Employee Food Service
United States
George's
277-05-6680
Terry B. Franklin, 1817 Tanow Pl, District
Heights, Md.
Alice Rivers
x
1817 Tanow Place
Food serv. Employee Food Service
United States
George's
277-05-6680
Terry B. Franklin, 1817 Tanow Pl, District
Heights, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02750
REG. NO.FOR
1. STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Katheryne H. FREEMAN			2a. DATE OF DEATH MONTH DAY YEAR January 28, 1987		2b. HOUR 5:25P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Emil Edmond Hellmich			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Barron Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-24-2227		17. INFORMANT ADDRESS Kathlyn P. Freeman same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY VASCULAR THROMBOSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 d
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					(b) <u>Anteriorly Heart Person with 30m.</u>
DUE TO, OR AS A CONSEQUENCE OF					(c) <u>acute fibrillation</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Perforation of Stomach, systemic heart infection, G.I. blood.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-86</u> 19____, to <u>1/28/87</u> 19____, that (I) (we) last saw the deceased alive on <u>1-28-87</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Roger B. Ingham</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>1/29/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger B. Ingham M.D.		22e. ADDRESS 6510 Kenilworth Ave., Riverdale, Md. 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 31 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 4 1987	
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified of same.

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20X POLYON FILM

42919 FEB-1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02151
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR 01 29 87		2b. HOUR 1335 ^{Hrs}	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LORA FREEMAN		3. SEX F		4. RACE W	
5. DATE OF BIRTH MONTH DAY YEAR 10 01 09		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.		10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.H.N.H.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE SECURE		12b. KIND OF BUSINESS OR INDUSTRY RADIO		13. STREET ADDRESS / ZIP CODE 2309 NEES LANE 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Robert McClelland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Helm		16. SOCIAL SECURITY NO. 164-38-8203	
17. INFORMANT Laurie F. Goldstein		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUDDEN DEATH</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. DATE OF OPERATION	
20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED		22. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		24. DATE OF OPERATION		25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		27. LOCATION STREET CITY OR TOWN COUNTY STATE 8317 Cherry Ln Laurel MD 20707		28. DATE SIGNED 1-29-87	
29. I certify that (I) (this hospital) attended the deceased from 10/21/86 to 1/29/87, that (I) (we) lost saw the deceased alive on 1/26/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) did not view the body after death.		30. SIGNATURE G. A. COMPTON MD		31. PHYSICIAN'S NAME (PRINT OR PRINT)	
32. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal		33. DATE		34. NAME OF CEMETERY OR CREMATORY St Paul's Evangelical C.	
35. LOCATION Pittsburg, Allegheny PA		36. FUNERAL DIRECTOR NAME Fleck Funeral Home		37. ADDRESS 2601 Sandy Sprg. Rd Laurel, MD 20707	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low and high temperatures of the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "I", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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040418 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02 / 52
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN B FUTCHIK			2a. DATE OF DEATH MONTH DAY YEAR JAN 05 87		2b. HOUR 1:50p M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 25 1915		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS MIN. 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John S. Cash		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah C. Rife		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-26-5541	
17. INFORMANT William E. Futchik		18. ADDRESS 8100 Allentown Road Ft. Washington, Md.		19. STREET ADDRESS / ZIP CODE 8100 Allentown Road 20744			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF DEHYDRATION AND MALNUTRITION (b) Dehydration + Malnutrition DUE TO, OR AS A CONSEQUENCE OF PANCREATIC CARCINOMA (c) Pancreatic Ca.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that my (this hospital) attended the deceased from 15 NOV 19 86 to 05 JAN 19 87 , that my (we) lost saw the deceased alive on 05 JAN 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.							
22b. SIGNATURE R. Kitchen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 05 JAN 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. KITCHEN		22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331-5300					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pudace			

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040186 JAN 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02153

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Raymond S. Galloway								Jan 2 1987		2		19		87		20	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 YRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	Dec 28 26 60		60 YRS.						Jan 2 1987		2		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.						Prince George									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Lanver		Frederickville Hosp		Carpenter		Union											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Howard		Lanver		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9136 Bryant Ave									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James Edwin Galloway		Carrie Nichols															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
Yes		100-28-306		Jacqueline Galloway													
				9136 Bryant Ave Lanver Md													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF															
Acute Myocardial Inf																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		Chronic Renal Failure & URTI															
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
		Diabetes															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
J. Rogers		M.D.		J. Rogers		Jan 2 1987											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		1/5/87		Meadowridge		Jesuit Balt. Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
F.H. Jones		JAN 7 1987		Julia D. Jones-Randall													
1601 Sandy Spring Rd Lanver Md																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
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(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

57 02154

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MARIE S. GAMBLE			2a. DATE OF DEATH MONTH 1 DAY 2 YEAR 87 12 28 87		2b. HOUR 4:50 AM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5495 Cedar Lane 21044	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 096-05-4989 D		17. INFORMANT ADDRESS 15300 Beaufort Place Silver Spring, MD. 20904		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (b) (this hospital) attended the deceased from <u>12/13</u> 19 <u>86</u> to <u>1/2</u> 19 <u>87</u> , that (b) (we) last saw the deceased alive on <u>1/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.						
22b. SIGNATURE <u>John Margolis MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John MARGOLIS MD				22e. ADDRESS 14333 Laurel Bowie Rd 56307 Laurel MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/5/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 5555 Twin Knolls Road, Columbia, MD. 21045				25. DATE RECEIVED BY COUNTY CLERK JAN 5 1987 Julia Denson-Randall		

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[Faint, mostly illegible text from a memorandum or letter, possibly containing names and dates.]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 02755

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Frank Garner			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Jan 17 1987			2b. HOUR M		
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 29, 1929	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 RS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Jan 17 1987	2d. HOUR 2:40	2e. MIN A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Keys, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10. CITY OR TOWN OF DEATH District Hts		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6906 Foster Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY US Capitol
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY PR George	13c. CITY OR TOWN Dist Hts	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6906 Foster Street 20747		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest W Garner Sr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Elva Cross					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-30-0957		17. INFORMANT ADDRESS Gloria S. Garner Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line, and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intercerebral cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 1-17-87		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, MD					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 21 Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm			25a. DATE REC'D. BY REGISTRAR JAN 28 1987			25b. REGISTRAR'S SIGNATURE <i>Julia [Signature]</i>		
Funeral Home			Suitland, Md.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

BP
DHMH - 17
(VR A15 ME (5))

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UNITED AIRWAYS AIRLINES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02756

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeffrey H. Gates										MONTH DAY YEAR 1 10 19 87		M 10 19 87	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH Jun 6, 1955	6. AGE (IN YEARS) 31 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 1 10 19 87		7d. HOUR 7:05A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.							
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Trucking					
13a. STATE D.C.										13b. COUNTY N/A		13c. CITY OR TOWN Washington	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 208 63rd St., N.E.		99999	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Gates				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vernie Young									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1980-1983 577-76-8239		17. INFORMANT ADDRESS Vernie Gates-Same as # 13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic trauma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6+xx 1 10 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION CITY OR TOWN COUNTY STATE Edmondson Rd at Springbrook Dr., Greenbelt, P.G. MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/11/87					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto. MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 1/14/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS H. S. WASHINGTON + SONS 4925 BURNBOUGH AVE., N.E.				25a. DATE REC'D. BY REGISTRAR JAN 30 1987				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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CHMH - 17
(VR 25 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

8 REG. NO. 02151

1. DECEASED NAME (TYPE OR PRINT) Jacqueline E. Gibbs			2a. DATE OF DEATH MONTH DAY YEAR 1/10/87		2b. HOUR 1205 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 19 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7302 Epping Ave. 20744
14. FATHER'S NAME FIRST MIDDLE LAST George W. John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Meldrum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 370-10-0845		17. INFORMANT Hollis Gibbs ADDRESS 7302 Epping Avenue Ft. Washington, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastric Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) CANCER of Stomach & Liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the physician) attended the deceased from 1/1/87 to 1/10/87 , that (I) (the) lost saw the deceased alive on 1/10/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE Mark H. Pillor		DEGREE M.D.		22c. DATE SIGNED 1/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. PILLOR		22e. ADDRESS 6188 Oxon Hill Rd Oxon Hill, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/87	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd.		25a. DATE REC'D. BY REGISTRAR JAN 13 1987	25b. REGISTRAR'S SIGNATURE Julia...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked other than 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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NAME

DATE

TIME

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02750

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond Joseph Golden			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR Jan 5 1988		2b. HOUR MIN 8:00 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 - 22 - 36	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 50	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan 5 1988	7d. HOUR MIN 8:00 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cable Splicer	
13a. STATE Maryland		13b. COUNTY Prince George's Mt. Rainier		13c. CITY OR TOWN 3108 Windom Road 20712	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Golden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adine Corbin		17. INFORMANT ADDRESS James Golden 11408 Cherry Hill rd. #102 Beltsville, Md. 20705	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 579-48-1088			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION
None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME
(TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/8/87	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince George's Md.
24. FUNERAL DIRECTOR (NAME) Francis Gasch's Sons Funeral Home, P.A.		25a. DATE REC'D. BY REGISTRAR	
4739 Baltimore Ave. Hyattsville, Md. 20781		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE WITHIN 24 HOURS. WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

JAN 13 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #4, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02/5/9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shedrick NMI GOODE			2a. DATE OF DEATH MONTH DAY YEAR January 28, 1987			2b. HOUR 12:05A _M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 18 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Handler		12b. KIND OF BUSINESS OR INDUSTRY Pvt	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9859 Good Luck RD 20706	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Goode				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Goode					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT Eartha Goode		ADDRESS 9859 Good Luck Rd 20706			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myeloproliferative Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Paroxysmal</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <u>Auto Vascular</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1-1, 1987, to 1-28, 1987, that (1) (we) last saw the deceased alive on 1-22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert Ruderman</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ruderman, M.D.				22e. ADDRESS 6510 Kenilworth Avenue, Suite 210 Riverdale, Md. 20737					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3 Feb 87		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi PG Maryland			
24. FUNERAL DIRECTOR NAME J.B. Jenkins FH 7474 Landover Rd Landover, Md.				25a. DATE REC'D. BY REGISTRAR JAN 30 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

HEATHMAN BOOK

042078 JAN 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02160
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LESLIE E. LAST: GOULD				2a. DATE OF DEATH MONTH: 1 DAY: 20 YEAR: 87 2b. HOUR: 2:05 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH: AUG DAY: 6 YEAR: 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HYATTSVILLE MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ORDAINED MINISTER		12b. KIND OF BUSINESS OR INDUSTRY CLERGY	
13a. STATE MD		13b. COUNTY PR. GEORGES		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: ARTHUR MIDDLE: LAST: GOULD		15. MOTHER'S MAIDEN NAME FIRST: ESTELLE MIDDLE: LAST: BAILEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 579-28-2206		17. INFORMANT ADDRESS: ELEANOR GOULD. 1902 BEECHWOOD RD. HYATT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>87</u> , to <u>1/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. Lady-Gottheim</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Skelly LADY-GOTTHEIM</u>				22e. ADDRESS <u>1106 Spring St. Silver Spring Md 20910</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>JAN. 23. 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY WASHINGTON D.C.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME: <u>Takoma Funeral Home, J. J. J. J.</u> ADDRESS: <u>254 Carroll St. N.W.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 27 1987</u>			
				25b. REGISTRAR'S SIGNATURE <u>Julia J. J. J.</u>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Figure 2.25: A graph of the function $f(x) = \sin(x)$ on the interval $[-\pi, \pi]$. The x-axis is labeled with $-\pi$, 0 , and π . The y-axis is labeled with -1 and 1 . The curve starts at $(-\pi, 0)$, reaches a minimum at $(-\pi/2, -1)$, crosses the x-axis at $(0, 0)$, reaches a maximum at $(\pi/2, 1)$, and ends at $(\pi, 0)$.

498

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4/21/20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This allows removal of carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8702761 REG. NO.					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST NELLIE GRACE GOWEN										JANUARY 27 1987				12:30P _M	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1890			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 96			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.						
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bureau Of Engraving - U.S. Govt.			12b. KIND OF BUSINESS OR INDUSTRY 20716						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. P.G. Mitchellville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3800 Lottsford Vista Rd. 20716		
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Burch					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Kerr					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-34-8945		
17. INFORMANT ADDRESS Nellie Werking Cheverly, Md. 20785										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cerebellar infarction DUE TO, OR AS A CONSEQUENCE OF (b) and upper Gastro intestinal DUE TO, OR AS A CONSEQUENCE OF (c) Bleeding PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) acute Urinary tract infection			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from 1/27 1987, to 1/27 1987, that (I) (we) last saw the deceased alive on 1/27 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED					
22b. SIGNATURE R. Dakheel					DEGREE M.D.					22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel, M.D.					22e. ADDRESS 14300 Gallant Fox Lane Bowie, Md. 20715										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/30/87			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.						
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md.					25a. DATE REC'D BY REGISTRAR FEB 3 1987					25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodner					

3

041342 JAN 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked affirm 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02162
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Anna MIDDLE C. LAST Graham			2a. DATE OF DEATH MONTH DAY YEAR 11/11/87			2b. HOUR 10:35 A.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 26, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Typist		12b. KIND OF BUSINESS OR INDUSTRY Federal Govt.	
13a. STATE None		13b. COUNTY None		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2971 McKinley Street 20013	
14. FATHER'S NAME FIRST Albert MIDDLE Mason LAST Carpenter				15. MOTHER'S MAIDEN NAME FIRST Paulina MIDDLE Sheerer LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 579-60-5729T		17. INFORMANT (Daughter) ADDRESS Jane G. Jones 5912 36th Avenue Hyattsville, Maryland 20782			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto Lung Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urone Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/11/87 1982 1982	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Renal Insufficiency</u>									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renal Insufficiency</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>12/2/82</u> , 19____, to <u>11/11/87</u> , 19____, that (2) I saw the deceased alive on <u>11/29/86</u> , 19____, and that in my opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)									
22b. SIGNATURE MBP <u>Patrick III MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick III MD				22e. ADDRESS 9221 Colonsville Rd Silver Spring, Md 2090					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 01/14/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE Julia Seaton-Randall	

042418 JAN 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara Christine Gramlich					2a. DATE OF DEATH MONTH DAY YEAR Jan. 27, 1987		2b. HOUR 12:30 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1915		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Beauty		
13a. STATE Maryland					13b. COUNTY Prince Georges		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Leitch Travers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Kasulke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT Ray Gramlich		18. ADDRESS same as 13 a.- e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus with Nephropathy & Neuropathy</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> A) WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 7-2, 1987, to 1-27, 1987, that (I) (we) last saw the deceased alive on 1-27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Thos H. Cleary					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-27-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Epiphany Ch. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forestville, Prince George's, MD				
24. FUNERAL DIRECTOR Lee Funeral Home, Inc Old Alexander Ferry Rd., Clinton, MD 20735					25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Bandiera			

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041436 JAN 21 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, REMOVAL, OR REINTERMENT.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02764	
1- FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eunice M. Gray										XX MONTH DAY YEAR 1-5 19 87	
2. DATE KNOWN OF DEATH MATED										2b. HOUR	
3. SEX										2c. DATE PRONOUNCED DEAD	
4. RACE										2d. HOUR	
5. DATE OF BIRTH MONTH DAY YEAR										6:15 p.m.	
6. AGE (IN YEARS LAST BIRTHDAY)											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										9. BALTIMORE CITY OR COUNTY OF DEATH	
7b. CITIZEN OF WHAT COUNTRY?										MD.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										Prince George's County,	
10. CITY OR TOWN OF DEATH										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE										Medical Tech.	
13b. COUNTY										20746	
13c. CITY OR TOWN										4652 Davis Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
George Smiley										Alice C. Clark	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										17. INFORMANT ADDRESS	
no										George Howard-son-4652 Davis Avenue	
16b. SOCIAL SECURITY NO.										421 20 8529	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										Suitland, Maryland	
IMMEDIATE CAUSE (a) Seizure Disorder and Thermal Injuries										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										Brain Tumor, NOS	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY?										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										Decedent collapsed after seizure while smoking causing housefire	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE										4652 Davis Avenue, Suitland, Prince George's Co., Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED	
ACTUAL SIGNATURE										1-7-87	
EXAMINER'S NAME (TYPE OR PRINT)										Dennis F. Smyth M.D.	
ADDRESS										111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE	
Burial										Jan. 13, 1987	
23c. NAME OF CEMETERY OR CREMATORY										Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE										Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR	
John T. Stewart										JAN 20 1987	
25b. REGISTRAR'S SIGNATURE										Julia T. ...	

07/84

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DHMH - 17
(VR A15 ME (5))

WITNESSES 110

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041488 JAN 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02105

REG. NO.

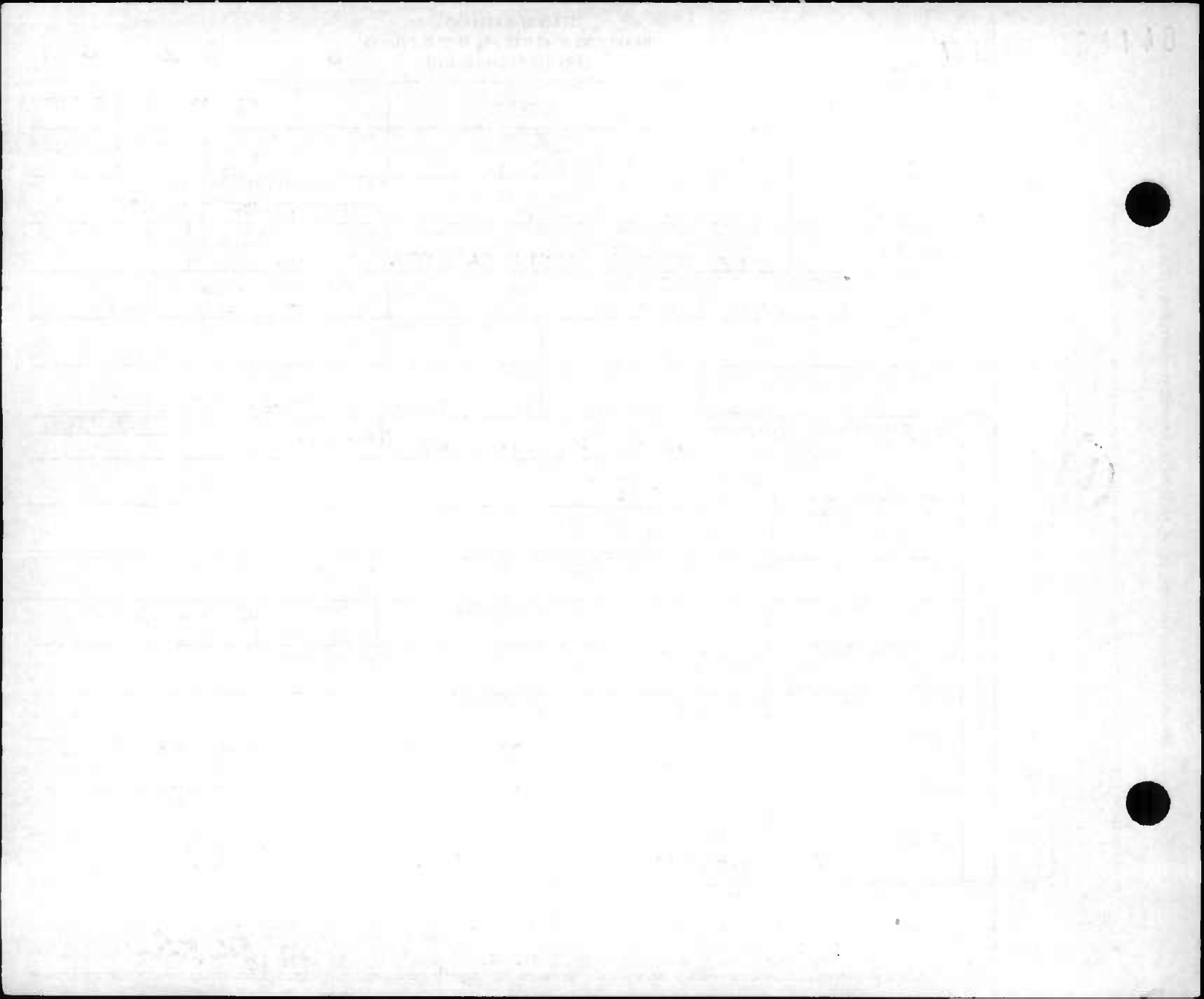
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA E. GREER			2a. DATE OF DEATH MONTH DAY YEAR 01 12 87		2b. HOUR 3 30PM M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S NURSING CARE CEN.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Chapel Oaks		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Fair		13e. STREET ADDRESS / ZIP CODE 1310 Nome Street 20743			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Josephine Richardson-1310 Nome Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ICVA</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>84</u> , to <u>1/12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/9/</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. DASHOTTAR MD</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. DASHOTTAR MD</u>		22e. ADDRESS <u>5632 ANNAPOLIS ROAD #7</u> <u>BLADENBURG, MD 20710</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-17-87		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Memo. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.	
24. FUNERAL DIRECTOR NAME T. C. Pinckney Spangler Funeral Home - 524 - 8th St., N. E.				25a. DATE REC'D. BY REGISTRAR JAN 20 1987			
				25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Their please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



040949 JAN 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02160

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST EDWARD	MIDDLE C.	LAST GRIGG	2a. DATE OF DEATH MONTH DAY YEAR 01 13 87		2b. HOUR 11:37P
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 27 25		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief of Prosthetics		12b. KIND OF BUSINESS OR INDUSTRY Veterans Administr.	
13a. STATE Maryland				13b. COUNTY Prince George		13c. CITY OR TOWN Bowie	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Grigg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Ellyn Nx Alley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Ellyn N. Grigg		ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Perforated Gastric Ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Melanoma</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> , 19 <u>87</u> , to <u>1/14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/14/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David S. Case</u>				22e. ADDRESS <u>3331 Superior Lane Bowie</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 16 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

041537 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02161

1. STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST EARL WARREN		MIDDLE GRIGSBY		LAST		7a. DATE KNOWN OF DEATH ESTIMATED 1-14-87 19		2b. HOUR M 7:33a	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 4 1942		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 1-14-87 19		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Horseman		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Virginia		13b. COUNTY Loudoun		13c. CITY OR TOWN Middleburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 226A 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Grigsby											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 228-54-3334		17. INFORMANT ADDRESS Hazel Grigsby same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic alcoholism with fatty liver</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>William M. Zane</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1-15-87							
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-87		23c. NAME OF CEMETERY OR CREMATORY West View				23d. LOCATION CITY OR TOWN COUNTY STATE Upperville Fauquier Va.					
24. FUNERAL DIRECTOR NAME <i>Lydia M. [Signature]</i>		ADDRESS Royston Funeral Home Middleburg, Va. 22117		25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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042325 JAN 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02168

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																																							
1. DECEASED NAME (TYPE OR PRINT) <i>Harry McCAMBRIDGE Grimes</i>										2a. DATE KNOWN OF DEATH <i>1-25 1987</i>										2b. HOUR <i>8:30</i>																																							
3. SEX <i>Male</i>										4. RACE <i>White</i>										5. DATE OF BIRTH <i>6-2-1927</i>										6. AGE (IN YEARS) <i>59</i> YRS.										7c. DATE PRONOUNCED DEAD <i>1-25 1987</i>										7d. HOUR									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>										7b. CITIZEN OF WHAT COUNTRY? <i>US</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>Service St.</i>																			
10. CITY OR TOWN OF DEATH <i>Clinton</i>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Southern Maryland Hospital</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Attendant</i>										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. STATE <i>Maryland</i>										13b. COUNTY <i>Pr. George</i>										13c. CITY OR TOWN <i>Brandywine</i>										13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										13e. STREET ADDRESS <i>16211 Ashbox Rd./20613</i>																			
14. FATHER'S NAME <i>Owen</i>										15. MOTHER'S MAIDEN NAME <i>Grimes Pearl W. Cage</i>										16. SOCIAL SECURITY NO. <i>213-24-3695</i>										17. INFORMANT <i>Leslie C. Gallagher</i>										18. ADDRESS <i>Silverwood Circle Annapolis, Md.</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>n0</i>										16b. SOCIAL SECURITY NO. <i>---</i>										17. INFORMANT <i>Leslie C. Gallagher</i>										18. ADDRESS <i>Silverwood Circle Annapolis, Md.</i>																													
19. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I DEATH WAS CAUSED BY: <i>Multiple Injuries with severe head injury.</i>										20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										21. DATE OF OPERATION <i>1/5/87</i>										22. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Repair of right ear aulson.</i>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY <i>12:00 P.M. 1-4 1987</i>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Driven in auto/auto impact.</i>										21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK																													
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) <i>Street</i>										21f. LOCATION <i>Rt 301 + Cedolville, Maryland, Pr. Geo, Md</i>										21g. CITY OR TOWN										21h. COUNTY										21i. STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22c. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22d. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>1-29-1987</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Memorial</i>										23d. LOCATION <i>Waldorf Charles Md.</i>																													
24. FUNERAL DIRECTOR <i>HUNT FUNERAL HOME</i>										25. DATE REC'D. BY REGISTRAR <i>JAN 28 1987</i>										25b. REGISTRAR'S SIGNATURE <i>Julie Tindon-Randall</i>										25c. REGISTRAR'S SIGNATURE																													

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DHMH - 17
(VR A15 ME (1))

04-0692 JAN 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02169
1- REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Elsie I. Grubbs										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/6 1987
3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 11-29-1914 6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.										2b. HOUR 8:00 P.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 1/6 1987
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County										
10. CITY OR TOWN OF DEATH East Pines 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5713 - 64th Avenue 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper 12b. KIND OF BUSINESS OR INDUSTRY Self Employed										
13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN East Pines 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 5713 - 64th Avenue 20737										
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Lineback 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Cline										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 578-09-7664 17. INFORMANT 2 Tailgate Glen, FAIRPORT, Linda E. Gottwald, New York 14450										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) chronic myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a										
None										
19a. DATE OF OPERATION None 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) None 21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John S. Rogers TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1/8/87										
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 1-10-87 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland										
24. FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS FUNERAL HOME, PA ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland 25a. DATE REC'D. BY REGISTRAR JAN 13 1987 25b. REGISTRAR'S SIGNATURE Julia Trish...										

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DHMH - 17
(VR A15 ME (5))

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

041220

JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

02770

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD J HALL			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1987		2b. HOUR 4:39 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Ocy. 24, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bagger		12b. KIND OF BUSINESS OR INDUSTRY Grocer		
13a. STATE Maryland			13b. COUNTY Pr. Georges		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1971		17. INFORMANT Loretta L. Hall		ADDRESS Same as #13a-e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF <u>CARDIOMYOPATHY</u> (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSION</u> (c) <u>hypertension</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> 19 <u>87</u> , to <u>7 Jan</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7 Jan</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>W. Reed Jaussi MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>7 JAN 87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAUSSI</u>				22e. ADDRESS <u>REED</u> MALCOLM GROW MED CTR AAFB, MD 20331-5300				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Myer Arlington Va.		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				6633 Old Alexander Ferry Rd Clinton, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 16 1987		
25b. REGISTRAR'S SIGNATURE <u>Julia Gordon</u>								

MEDICAL CERTIFICATION

99

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified.

BP



042951 FEB 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Medical Examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST RONALD	MIDDLE T.	LAST HALL	2a. DATE OF DEATH MONTH DAY YEAR 1-17-87		2b. HOUR 6.25A M		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 2 1946		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPPLY CLERK		12b. KIND OF BUSINESS OR INDUSTRY OFFICE U.S. PATENT	
13a. STATE MARYLAND					13b. COUNTY PR. GEORGE		13c. CITY OR TOWN SUITLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JAMES A. HALL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN E. MILLS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam		17. INFORMANT ADDRESS Deborah Hall 401 Chaplin St. SE Wash., DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercerebral Haemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Systemic Cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Systemic Sepsis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>End Stage Renal Dis., Ch. Pancreatitis.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16/87</u> to <u>1/17/87</u> that (I) (we) last saw the deceased alive on <u>1/16/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jaswinder Sidhu</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASWINDER SIDHU				22e. ADDRESS 9470 ANNAPOLIS RD LANHAM MD 20706					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-23-87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland			
24. FUNERAL DIRECTOR NAME Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. D.C.				25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Rodgers</u>			

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042545 FEB 2 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02772
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice Trott HANCE				2a. DATE OF DEATH MONTH DAY YEAR January 24, 1987				2b. HOUR 4:50AM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 19 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE Sixes Road 20678	
14. FATHER'S NAME FIRST MIDDLE LAST Allen B Trott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Thomas L. Hance same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Polycystic Kidneys; Chronic Renal Failure Hemodialysis Peritoneal Dialysis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 15 19 87 to Jan 24 19 87 , that (I) (we) lost saw the deceased alive on Jan 23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE MD MRCP				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-27-87		23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION CITY OR TOWN COUNTY STATE Prince Frederick Cal MD			
24. FUNERAL DIRECTOR NAME newch Funeral Home Owings				25a. DATE REC'D. BY REGISTRAR JAN 29 1987					
				25b. REGISTRAR'S SIGNATURE [Signature]					

RECEIVED
JAN 10 1964
U.S. AIR FORCE

042802

①

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and" and "the" are faintly visible.]

043070 FEB 15 87

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02173
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FABIAN Fabian Egan HANSEN			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1987		2b. HOUR 3:00
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 23, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH College Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4909 Hollywood Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4909 Hollywood Road / 20740	
14. FATHER'S NAME FIRST MIDDLE LAST James Egan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Dean			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 504-22-1823B		17. INFORMANT ADDRESS Patricia S. Warren, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease					5 years.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12/15 19 86 to 1/31 19 87 , that (I) (we) last saw the deceased alive on 12/15 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (and not) view the body after death.					
22b. SIGNATURE Carl I. Schoonberger		DEGREE MD		22c. DATE SIGNED 1/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoonberger		22e. ADDRESS 4701 Randolph Rd Rockville, MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-3-87		23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Missouri Valley, Iowa		24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS 1804 T Street, NW, Washington, DC 20009			
25. DATE RECEIVED BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

W. J. K. 1944

J

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 74

REG. NO.

1- FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

T.
ELIZABETH HARBOURT

2a. DATE OF DEATH MONTH DAY YEAR

JAN 4, 1987

2b. HOUR

12:05p M

3. SEX

Female

4. RACE

Cauc

5. DATE OF BIRTH

MONTH DAY YEAR
Sep 30, 1897

6. AGE (IN YEARS LAST BIRTHDAY)

89y

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georg's

MD.

10. CITY OR TOWN OF DEATH

Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Greater Laurel Beltsville hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Bookkeeper

12b. KIND OF BUSINESS OR INDUSTRY

Drug Exch.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Howard

13c. CITY OR TOWN

Laurel

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

9150L Bourbon St 20707

14. FATHER'S NAME

FIRST

George

MIDDLE

Marion

LAST

Tarr

15. MOTHER'S MAIDEN NAME

FIRST

Wilhemina

MIDDLE

LAST

Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

579222859

17. INFORMANT

Harry W. Harbourt Elkridge, Md. 21227

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebro Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Right Cerebral Vascular Accident 4 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0

Cerebral Artery Disease, Hypertension

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/31/86 to 1/4/87, that (I) (we) lost saw the deceased alive on 1/3/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

1/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

1/6/87

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN

Brentwood

COUNTY

P.G.

STATE

Md.

24. FUNERAL DIRECTOR

7601 Sandy Spring Rd.

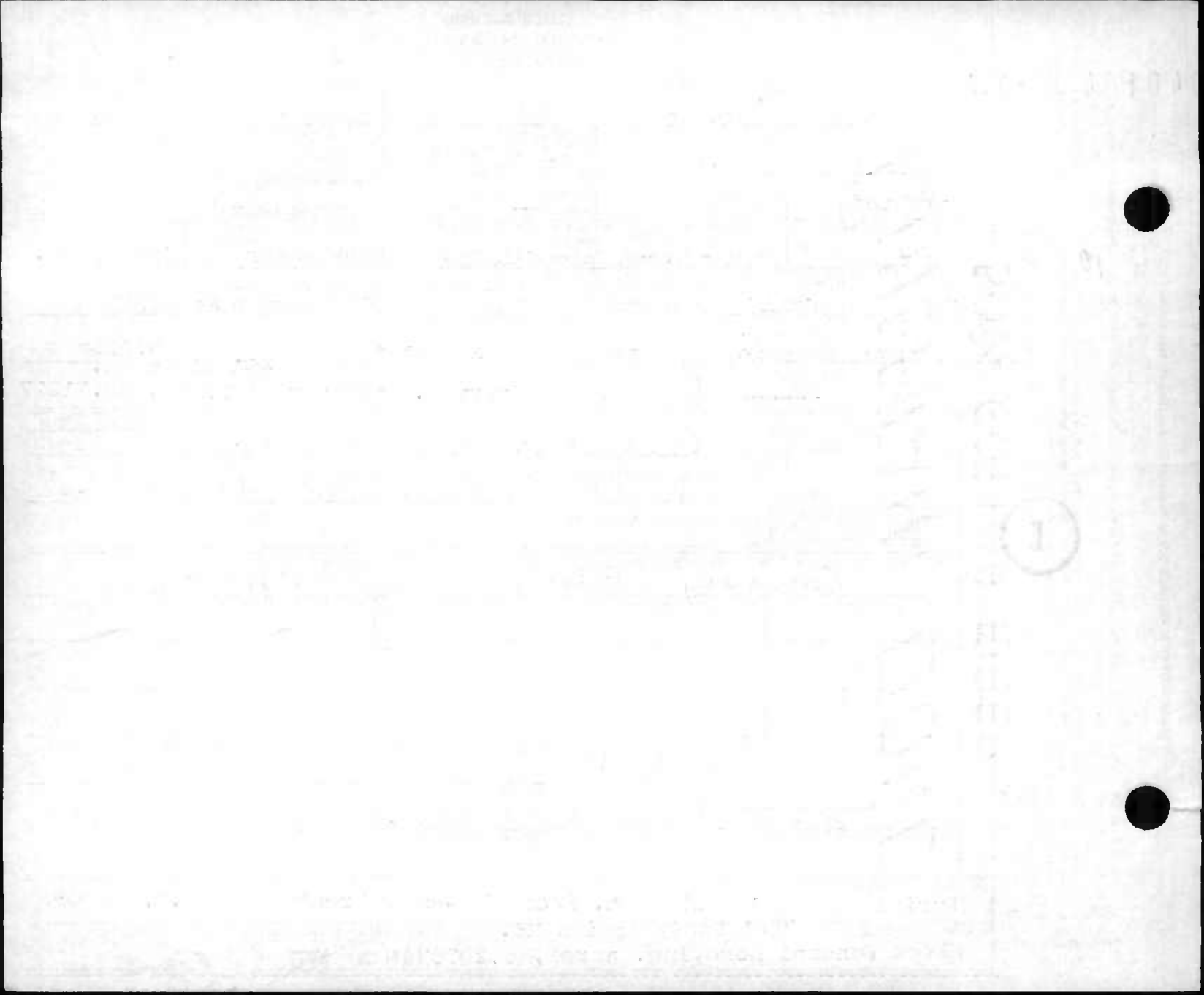
Fleck Funeral Home, Inc. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR

JAN 7 - 1987

25b. REGISTRAR'S SIGNATURE

Julia Henderson-Pedraza



041597 JAN 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 15

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARGARET ELLEN HARMON			MONTH DAY YEAR JANUARY 14 1987			2:25P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
female	white	MONTH DAY YEAR Jan 14 1918		69 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA			Prince George's MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' Hospital of Pr. Geo. Co.			manager		apartment		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Anne Arundel Lothian			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Lyons Court 20711			
14. FATHER'S NAME FIRST MIDDLE LAST Frank R Sames			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nell Harrington Cook					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no			n/a		Dr James P. Dabbs Leonardtown Md 20650			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central nervous system failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>brain metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from <u>Jan 14 1986</u> to <u>Jan 14 1986</u> , that (I) (we) last saw the deceased alive on <u>Jan 14 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Martin D. Weltz</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1 / 14 / 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WELTZ			22e. ADDRESS 1505 Greenway Cir Prince Georges MD 20710					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial			1 17 87		All Hallows Cemetery		Edgewater Anne Arundel MD	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Rausch Funeral Home			JAN 21 1987			1 via [signature]		

MEDICAL CERTIFICATION

19

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all Bonapapers, pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to examine the body.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

100-100000-100

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/1/81 BY 1043/SP/STP

U.S. GOVERNMENT PRINTING OFFICE: 1975

42857 FEB -4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02110
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ORLEAN HARRINGTON		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-20 19 87		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8-12-70	6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7c. DATE PRONOUNCED DEAD 1-20 19 87		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD		
10. CITY OR TOWN OF DEATH Prince George		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Construction Labor
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS (20743) 1201 Dunbar Oak Drive		
13b. COUNTY Maryland		13c. CITY OR TOWN Capital Hts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James B. Harrington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Dean Bumpers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 4 May 43 11-45 212-12-5228		17. INFORMANT ADDRESS Capitol Heights, Maryland Eleo Harrington 1201 Dunbar Oak Dr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiac vascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 1-20-87
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01/24/87	23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.Co. Maryland
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home		25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall
ADDRESS 3831 Ga. Ave. NW; Washington, DC. 20011				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

12-17-48

12-17-48

1

12-17-48

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK E. HARRIS			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 26 1987			2b. HOUR 11:30AM	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR February 14, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Deep Creek VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Holly Farms		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE VA.		13b. COUNTY Accomack		13c. CITY OR TOWN Accomack		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ethel Harvey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes			
16a. SOCIAL SECURITY NO. 225-18-3979		17. INFORMANT ADDRESS Shirley Belsches 6508 DAWWOOD DR. LANHAM					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CARCINOMA LEFT LUNG							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 1. 25 19 87 to 1. 26 19 87, that (I) (we) last saw the deceased alive on 1. 25 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE VP Singh		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1. 27. 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Virender P. Singh, M.D.		22e. ADDRESS 5632 Annapolis Road, #9, Bladensburg, Md. 20710					
23a. BURIAL, CREMATION, REMOVAL (ECIF) Burial		23b. DATE Jan. 31, 1987		23c. NAME OF CEMETERY OR CREMATORY Accomack church		23d. LOCATION CITY OR TOWN COUNTY STATE Accomack Va.	
24. FUNERAL DIRECTOR NAME C.C. Humbles		ADDRESS Accomack, Va.		25a. DATE REC'D. BY REGISTRAR JAN 27 1987			
25b. REGISTRAR'S SIGNATURE Julia S. S. S. S.							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as true, 18 shows any injury, or other traumatic event, the medical examiner must be notified or the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

MEMORANDUM

TO : THE SECRETARY OF DEFENSE

FROM : THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

7

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 18

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anne D Hereford			2a. DATE OF DEATH MONTH DAY YEAR 1 20 87			2b. HOUR 1A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 7 1888		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. Howard Savage		13b. CITY OR TOWN Savage		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 8805 Baltimore Str. 20763			
14. FATHER'S NAME FIRST MIDDLE LAST William M. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Walker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-03-9181		17. INFORMANT Virginia Brann		ADDRESS same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Longstanding Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/20/87 1983 1983	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Serious Diabetes									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 3/14/85 , 19____, to 1/20/87 , 19____, that (1) (we) lost 1/19/87 above, (1) (we) did not view the body after death.									
22b. SIGNATURE GB Patrick MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick MD				22e. ADDRESS 9221 Lakesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION Brentwood P.O. Md.			
24. FUNERAL DIRECTOR NAME 7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707				25a. DATE REC'D. BY REGISTRAR 1/29/87		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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40363 JAN 12 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 02779

1. DECEASED NAME (TYPE OR PRINT) Harriett Irene Hess.			2a. DATE OF DEATH MONTH DAY YEAR 1 - 6 - 87		2b. HOUR 6:09 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN. 2, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1627 DREXEL STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REGISTERED NURSE		12b. KIND OF BUSINESS OR INDUSTRY SAME
13a. STATE FLA.	13b. COUNTY 13b	13c. CITY OR TOWN ZELLWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. BOX 42 - 32798	
14. FATHER'S NAME FIRST MIDDLE LAST DAM WARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE WIGAL			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 269-363701		17. INFORMANT ADDRESS CLARENCE R. HESS, P.O. BOX 42 ZELLWOOD FLA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-29 19 86 to January 19 87 , that (I) (we) last saw the deceased alive on 12-29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Kai-Yin Yung	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-7-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yung, MD		22e. ADDRESS 8926 Woodyard Rd #201 Clinton, MO 20235	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY East Oak Grove Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Morgan Town W. Va
23e. FUNERAL DIRECTOR 254 Carroll St. N. W. D.			
DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 9 1987 Julia Steiner-Rublee			

DHMH - 16 COM 7-84
(VRA 5, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 80
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Josephine Elizabeth Hildebrand			2a. DATE OF DEATH MONTH DAY YEAR Jan. 21, 1987		2b. HOUR 7:18a M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Suitland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4233 Silver Hill Rd., Suitland, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Suitland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4233 Silver Hill Rd., apt. C 20746
14. FATHER'S NAME FIRST MIDDLE LAST Richard Phipps		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mayme Rampey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT son ADDRESS 9 Hunt Ct. Robert Hildebrand, Waldorf, MD 20601	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Epidermoid Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Months Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>January 19 87</u> to <u>January 19 87</u> , that (I) (we) lost saw the deceased alive on <u>January 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/23/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Louis Kaufman, MD		22e. ADDRESS 8926 Woodyard Rd, Clinton, MD 20735 #602	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 24, 1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges MD
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR JAN 29 1987	25b. REGISTRAR'S SIGNATURE
6633 Old Alexander Ferry Rd., Clinton, MD 20735			

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042079 JAN 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02781
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) TODD A. HILTERBRICK			2a. DATE OF DEATH MONTH DAY YEAR JAN 20 1987			2b. HOUR 7:33 A.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14 1986		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 4 MOS. 4 DAYS		7. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none	
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Med. CTR, Base		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a. STREET ADDRESS / ZIP CODE 114 Ryon Court 20601	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 114 Ryon Court 20601	
14. FATHER'S NAME FIRST MIDDLE LAST Paul E. Hilterbrick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beverly Rood		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Paul Hilterbrick; See #13 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PREMATURITY, 25 WEEKS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 24 hrs 4 months		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>14 SEPT</u> , 19 <u>86</u> , to <u>20 JAN</u> , 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>20 JAN</u> , 19 <u>87</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.		22b. SIGNATURE <u>James H. Harrison</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 20 JAN 87	
22d. HARRINGTON, JAMES, CAPT, USAF, MC 033-40-0972 NEONATOLOGIST 9366		22e. ADDRESS MALCOLM GROW USAF MED CTR 7MACY/86RA		22f. ADDRESS ANDREWS AFB, WASHINGTON, D.C. 20331-5300					
23a. BURIAL OR CREMATION (SPECIFY) Burial		23b. DATE Jan. 26 1987		23c. NAME OF CEMETERY OR CREMATORIUM ANDREWS AFB, WASHINGTON, D.C. 20331-5300		23d. LOCATION Rose Township, Michigan		23e. DATE REC'D. BY REGISTRAR JAN 27 1987	
24. FUNERAL DIRECTOR NAME Ives-Pearson F.H. Arlington, Va. 22201		24b. ADDRESS Lane Heights Cemetery		24c. REGISTRAR'S SIGNATURE <u>John R. Pearson</u>					

10-10-1910

1

WASHINGTON, D.C.
OCTOBER 10, 1910
RECEIVED

ALSO SENT BY AIR MAIL
OCTOBER 10, 1910
ANDREW J. WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

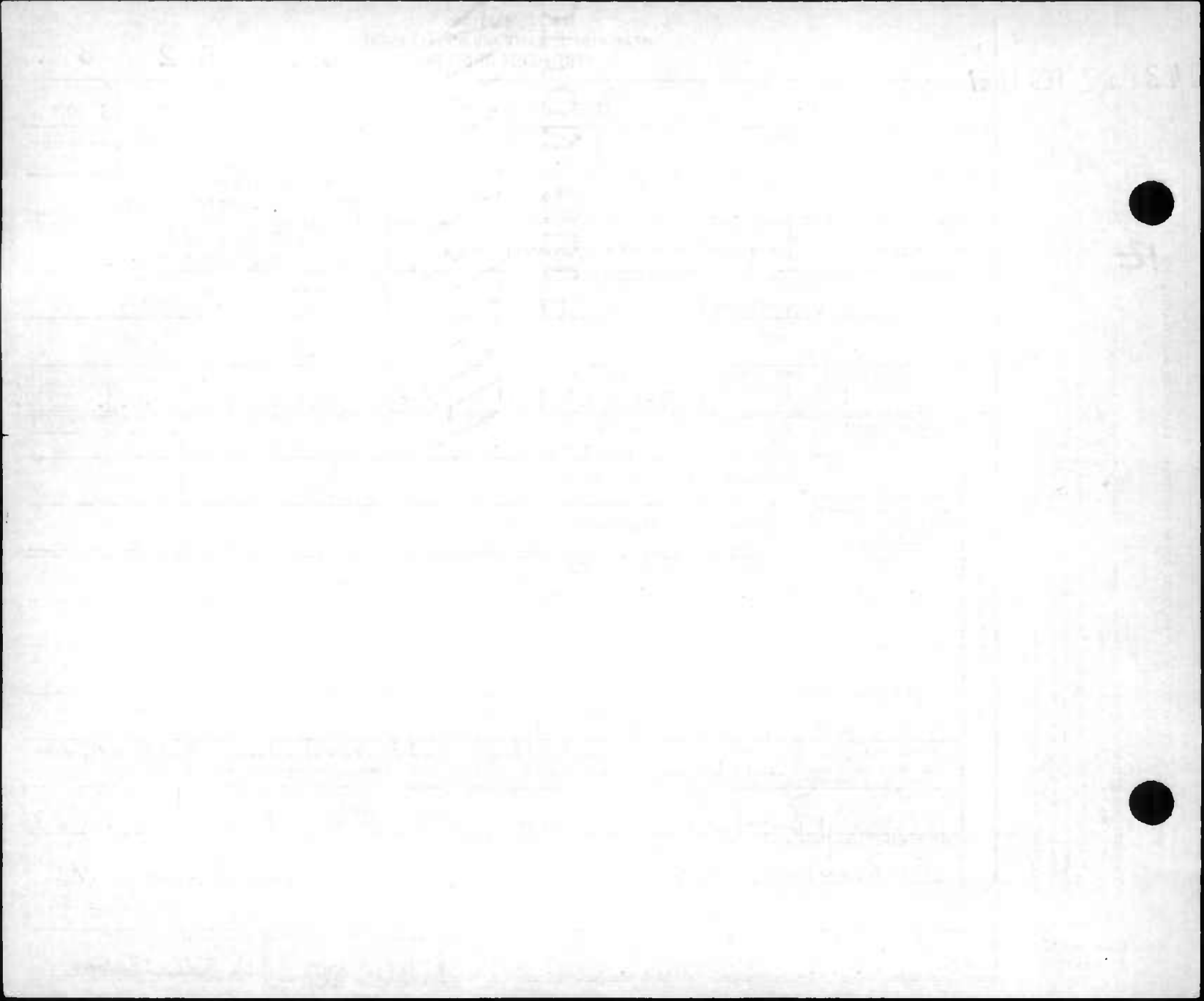
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02782
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
GUY Raymon HINEGARDNER		01-24-87		3 00PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	73 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.		PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER		Insurance Broker		Private
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6115 Arbor St. 20785		
Maryland Prince Georges Cheverly					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
William Carson Hinegardner		Lena D. Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT (Son) ADDRESS		
No		N/A	577-09-0457 William Hinegardner, 1209 Cedar Ln. M.D. 21037.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
<u>Sepsis. Diabetic. Comp. Heart Failure. Dementia. Ulcers.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1-12-87 to 1-24-87, that (1) (we) last saw the deceased alive on 1-24-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
E.H. Burnsides MD		MD			1.24.87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
E.H. Burnsides MD		1 Hospital Prince Georges MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremation	1-25-87	Lee Crematory	Washington, District of Columbia		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME J. William Lee's Sons Company					
300-4th St. N.E. Washington, D.C. 20002		FEB 04 1987		Julia Anderson-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 2 1 8 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SENORA HINSON		2a. DATE OF DEATH MONTH DAY YEAR 1-9-87		2b. HOUR 7:44 AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Aug. 24, 1908		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES Co MD	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARY LAND HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Md.	13b. COUNTY P.G.	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5002 Harpers Dr. 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-30-3928		17. INFORMANT ADDRESS Maud Carr-5002 Nash St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy Toxic DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock Hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Alcohol DM, Neuropathy					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-8-87 to 1-9-87 , that (I) (we) lost saw the deceased alive on 1-8-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Abul Hasan U Ansari		DEGREE MD		22c. DATE SIGNED 1-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI		22e. ADDRESS 8926 Woodyard Road #101 Clinton Md. 20735			
23a. BURIAL (CREMATION, REMOVAL)		23b. DATE 1/15/87		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATL. MEN. PK. LAUREL, P.G. MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR JAN 30 1987			
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON + SONS		ADDRESS 4425 BURRHEAD AVE. N.C.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

1

040474 JAN 12 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 / 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD HOLLAND			2a. DATE OF DEATH MONTH DAY YEAR Jan 3, 1987		2b. HOUR 1:04A M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Dec 1, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63y YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wood & Metal Repair		
13a. STATE MD		13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Ailene Holland (Wife) same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSEPTIC Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident and Septicemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Hypertensive Cardiovascular Disease, Ventricular arrhythmia, Renal Insufficiency					
19a. DATE OF OPERATION 12/13/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Repair Abdominal Aortic Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/9/86 , 19____, to 1/3/87 , 19____, that (I) (we) lost saw the deceased alive on 1/2/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE William A. Wannen		DEGREE MD		22c. DATED SIGNED 1/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.A. Wannen		22e. ADDRESS 321 Prince Georges St Laurel, 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-87		23c. NAME OF CEMETERY OR CREMATORY St. Rest Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey, Balt. Co., Maryland					
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR JAN 7 1987	
		25b. REGISTRAR'S SIGNATURE Julia T. [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be examined by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 85

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST JOHN MIDDLE E. LAST HOLLAND		2a. DATE OF DEATH MONTH DAY YEAR 01/26/87		2b. HOUR 12 24P M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 09/13/25 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL & MC		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY Specialist			
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Riverdale	
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius F. Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Holland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 025-09-8178		17. INFORMANT 6709 Hamilton Street Robert C. Holland Riverdale, Md. 20737	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Hepatic Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 month

1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic Renal Failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>86</u> , to <u>1/26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/26</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.					
22b. SIGNATURE <u>Stall</u>		DEGREE MD		22c. DATE SIGNED 1/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) POLAK		22e. ADDRESS 4700 AUTH PL. Camp Springs			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem	
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg. Md.		25a. DATE REC'D BY REGISTRAR FEB 3 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-13-34

1

188 384

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02786

REG. NO.

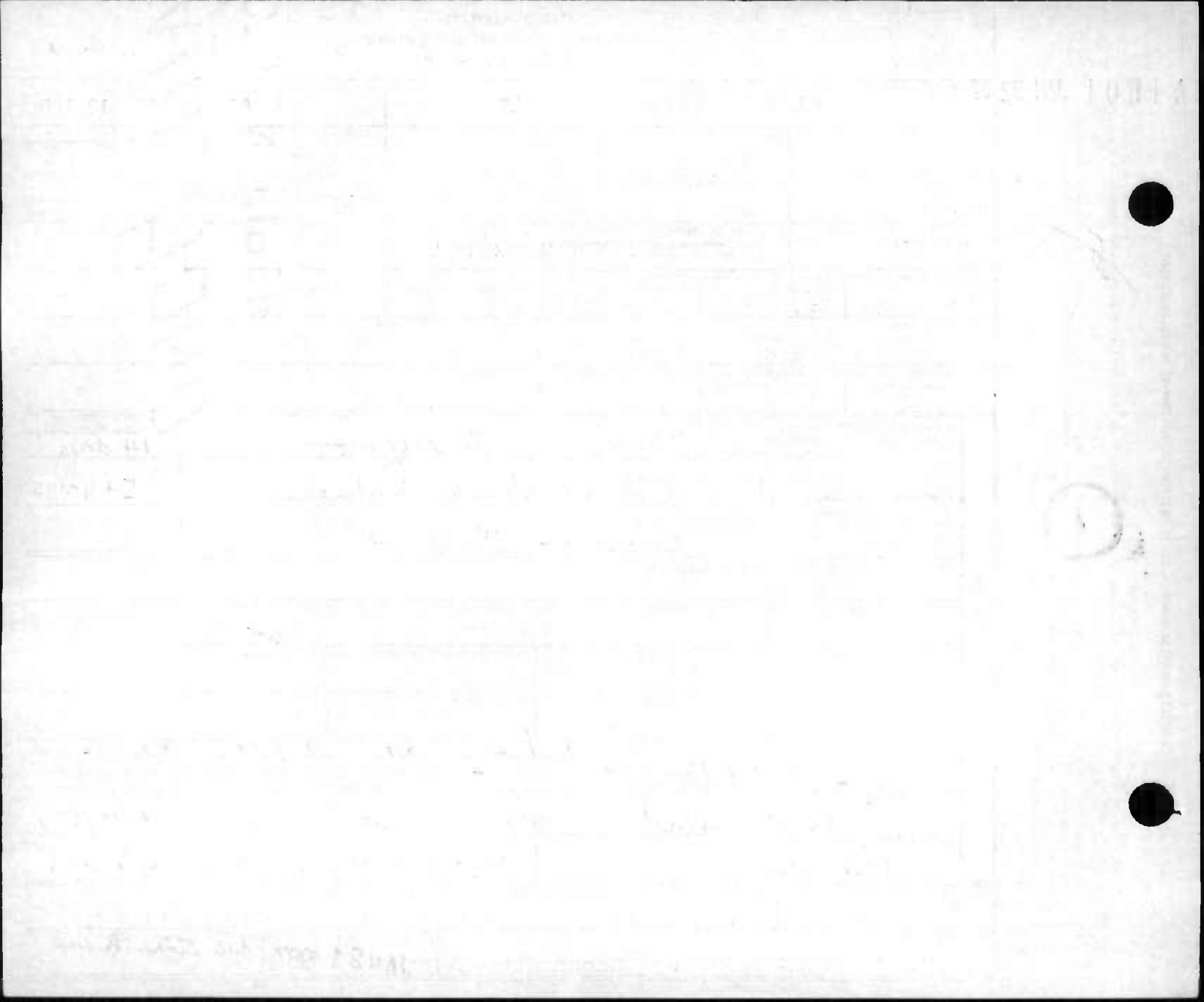
DECEASED NAME (TYPE OR PRINT)		FIRST HELEN	MIDDLE Theresa	LAST HOLT	2a. DATE OF DEATH MONTH DAY YEAR 01 18 87		2b. HOUR 12:10P ^M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Loveville
				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD 2 Box 153 20656		
14. FATHER'S NAME FIRST MIDDLE LAST James Alexander Young				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Somerville				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17. INFORMANT ADDRESS		17b. KIND OF BUSINESS OR INDUSTRY		
No				Paul L. Holt		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcus Septicemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal failure</u>								5+ years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>87</u> , to <u>1/18</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>1/18</u> , 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Shirley Adair</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) POLLOCK				22e. ADDRESS 4700 AUTH PL. CAMP SPRINGS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Queen of Peace		23d. LOCATION CITY OR TOWN COUNTY STATE Helen St. Mary's Md.		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, MD		25a. DATE REC'D. BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE Debra Gordon-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a medical examination must be performed.)



040191 JAN 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 87

FOR
STATE
REGISTRAR

REG. NO.

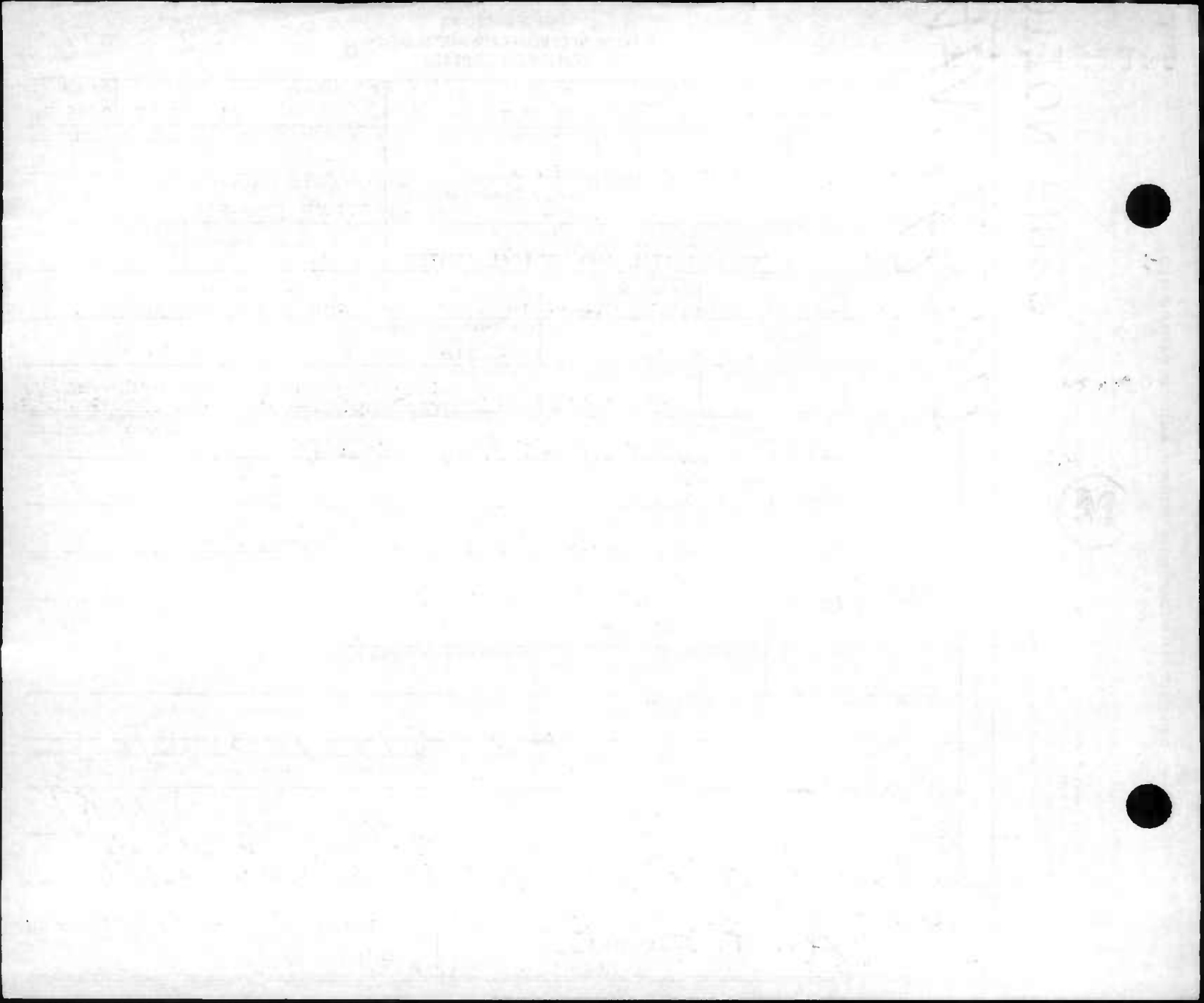
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR			
SUSANNA R HOLT						01 03 87				2 46 P.M.					
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black		Feb. 26, 1914			72 YRS.			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Georgia		USA					PRINCE GEORGE'S MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER										Retired			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland				Prince George's		Cheverly		NO <input type="checkbox"/> YES <input type="checkbox"/>		1600 Jutewood Avenue 20785					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Grant Reid				Lula Hollins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
no				175 12 1821				1600 Jutewood Avenue-Cheverly, Shirley Prophet-daughter-Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Bilateral multilobar pneumonia</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Renal Failure. Chronic Brain Syndrome.</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-3-87</i> to <i>1-3-87</i> , that (I) (we) lost saw the deceased alive on <i>1-3-87</i> above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated															
22b. SIGNATURE <i>John T. Stewart</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22c. DATE SIGNED <i>1/4/87</i>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Crossland M.D.</i> 22e. ADDRESS <i>5711 SARVIS Ave. Suite 302 Riverdale Maryland 20737</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Jan. 8 1987		Cedar Hill Cemetery				Suitland, Maryland					
24. FUNERAL DIRECTOR NAME <i>John T. Stewart</i> ADDRESS <i>Stewart Funeral Home-4001 Benning Road, N.E.</i>															
25a. DATE REC'D. BY REGISTRAR <i>JAN 7 1987</i> 25b. REGISTRAR'S SIGNATURE <i>John T. Stewart</i>															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



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040294 JAN - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 88

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Berdella			2a. DATE OF DEATH MONTH DAY YEAR January 3 1987			2b. HOUR 7:25 PM				
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 11, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel-Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. STATE Penn			13b. COUNTY Somerset		13c. CITY OR TOWN Meyersdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 422 4th Avenue 15552-9999	
14. FATHER'S NAME FIRST MIDDLE LAST Filmore Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Hutzell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 168 50 7120			17. INFORMANT ADDRESS Marna Hiers 14202 Adkins Road Laurel, Maryland 20708				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) advanced Cardiovascular Catheterization									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 22 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 13 87					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 14202 Laurel Park Dr Laurel Md 20708					
22a. I certify that (I) (this hospital) attended the deceased from 1-3-87 to 1-3-87 , that (I) (we) last saw the deceased alive on 1-3-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 1-3-87	
22b. SIGNATURE B G Manejwala MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. PHYSICIAN'S NAME (TYPE OR PRINT) B G Manejwala MD			23b. ADDRESS 14202 Laurel Park Dr Laurel Md 20708							
23c. BURIAL, CREMATION, REMOVAL Burial			23d. DATE Jan 6, 1987		23e. NAME OF CEMETERY OR CREMATORY Union Cemetery		23f. LOCATION CITY OR TOWN COUNTY STATE Meyersdale, Pennsylvania			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md						25a. DATE REC'D. BY REGISTRAR JAN 7 1987		25b. REGISTRAR'S SIGNATURE John Anderson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 7 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth S Hudson			2a. DATE OF DEATH MONTH DAY YEAR 1 31 87		2b. HOUR 5:51 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 26 1901	6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Riverdale	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4504 Queensbury Rd. 20737
14. FATHER'S NAME FIRST MIDDLE LAST Franklin A.M. Shafer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-42-4294	17. INFORMANT ADDRESS Mr. Lawrence F. Hudson, 4504 Queensbury Rd., Riverdale, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Hrs
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE MYOCARDIAL INFARCTION		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE					
19a. DATE OF OPERATION 1/30/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED skin graft	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-9 , 19 87 , to 1-30 , 19 87 , that (I) (we) lost saw the deceased alive on 1-30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE K. Joseph Mathew		DEGREE	22c. DATE SIGNED 1-31-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. JOSEPH MATHREW		22e. ADDRESS 6510 Kenilworth Ave Riverdale, Md 20737			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.
24. FUNERAL DIRECTOR Smath Keeney Basford P.A. Funeral Home		25. DATE REC'D. BY REGISTRAR FEB 06 1987	25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall
106 E. Church St., Frederick, Md. 21701			

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40562 JAN 3 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02790

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leonard J. Hurley		2a. DATE OF DEATH MONTH DAY YEAR January 8, 1987		2b. HOUR 9:07a.m.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 16 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Ft. Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3715 Oaklawn Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer	12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.
13a. STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Hurley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellie Schmidt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 502-20-6585		17. INFORMANT ADDRESS Bernardine A. Hurley 3715 Oaklawn Rd. Ft. Washington, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) leiomyosarcoma of the stomach DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) Dr. Kai-Yin Yew attended the deceased from June 11-21 1986 to Jan 8 1987 , that (I) (X) lost saw the deceased alive on above, (I) (X) did not view the body after death.				
22b. SIGNATURE Kai-Yin Yew, M.D.		DEGREE M.D.		22c. DATE SIGNED 1-9-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yew, M.D.		22e. ADDRESS 8926 Woodyard Rd., #201, Clinton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/12/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 91
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
William T. Hyde		1-9-87		4:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	3 15 1900	86	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	USA		Prince George MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Greenbelt	Greenbelt Nsg. Center	Project Manager	Gulf Oil Corp.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.	Pr. George's	Bowie	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12619 Safety Turn 20715	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Charles	Blanche	NO			
16b. SOCIAL SECURITY NO	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
179-03-3696	Garrett R. Hyde	IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 15 YEARS			
		DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ATHEROSCLEROSIS 20 YEARS			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-14-1983, to 1-9-1987, that (I) last saw the deceased alive on 12-12-1986, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (not) view the body after death.					
22b. SIGNATURE	DEGREE	22c. DATE SIGNED			
John Cosma M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	1-9-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
JOHN COSMA, M.D.	14300 GALLANT FOX LA, BOWIE, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY STATE	
Cremation	JAN 9, 1987	Metropolitan Crematory	Alexandria, Fairfax, Virginia		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Beall Funeral Home	JAN 12 1987	Julia Gordon-Peterson			

1

Charles

Alfred

Hyde

Blanche

M.

Robert

NO

- - -

173-23-3800

George R. Hyde, Jr., Virginia, 20112

12019 21st Street

Project Manager: GALT, GIL, 1079

Dr. George's 20112

20112 20112

USA

Project Manager

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1000 Annapolis Road, Alexandria, Virginia

1000 Annapolis Road

1000 Annapolis Road

1000 Annapolis Road

1000 Annapolis Road

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02792
REG. NO.

1- REGISTRAR FOR STATE		DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ruth</i>		MIDDLE <i>Louise</i>		LAST <i>Jackson</i>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>1-25 19 87</i>		2b. HOUR M <i>8 1/2</i>					
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-14-30</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>56 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS <i>56 YRS.</i>		IF UNDER 24 HRS. HOURS MIN. <i>56 YRS.</i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>1-25 19 87</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Chattanooga Tenn.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Cheverly</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George's Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Maryland</i>				13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3042 Brightseat Road, #203</i>				20706			
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Jackson, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Naomi Alice Dobbs</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>414 46 7413</i>					
17. INFORMANT ADDRESS <i>Judy D. Jackson-daughter-7600 Fon-</i>				18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic retinopathy and complications</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				Tainebleau Drive, New Carrollton, Md				INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Hypertension, valvular heart disease</i>												19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>1-25-87</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jan. 31, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park Landover, Maryland</i>				23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <i>John T. Stewart, III</i>				ADDRESS <i>Stewart Funeral Home-4001 Benning Road, N.E. 30 1987</i>				25a. DATE REC'D. BY REGISTRAR <i>1-30-87</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (5))

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 1 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROZALIA JAEGER			2a. DATE OF DEATH MONTH DAY YEAR 01 31 87		2b. HOUR 4:50A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 16 07		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMENAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ZSIGMOND - SZOKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA - BENCEDI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS 6312 MARYWOOD ROAD BETHESDA, MD. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mesenteric Infection</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>diffuse Atherosclerotic Disease s/p M.I. s/p LFT BKA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (b) (his hospital) attended the deceased from <u>7/5</u> , 19 <u>87</u> , to <u>1/31</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Don H. Yablonski</u>		DEGREE MD		22c. DATE SIGNED 1/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonski		22e. ADDRESS 10300 Greenbelt Rd, Seabrook, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB. 3, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG.CO. MARYLAND		23e. DATE REC'D. BY REGISTRAR 9 1987			
24. FUNERAL DIRECTOR NAME WW CHAMBERS CO., INC.		25a. REGISTRAR'S SIGNATURE Julia Anderson			

IMPORTANT: If item 21 is marked "yes", item 18 must include any injury, or other traumatic event, or medical examination that is certified at time of death.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02794

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST LOIS		MIDDLE May		LAST JAMES		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-1-87 19		2b. HOUR M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 13, 34		6. AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-1-87 19		7d. HOUR 11:48 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH AAFB		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Pr GEorge		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3505 N Forest Edge		20747	
14. FATHER'S NAME FIRST MIDDLE LAST Louis R. May				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavenia E. Vincent				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO.				17. INFORMANT Laura Petrillo				ADDRESS 3061 Symphony Lane Huntingtown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation and carbon monoxide</u> DUE TO, OR AS A CONSEQUENCE OF, <u>intoxication</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? between 8 & 11 PM, 1-1-87						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in a housefire									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3505 N. Forest Edge Rd. Forestville, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1-2-87					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6 Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Funeral Home Suitland, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

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W. J. D. W. J. D. W. J. D.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02195

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Christine L JARBOE			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1987		2b. HOUR 8:35PM		
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov 23 1909		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY PR GEE.		13c. CITY OR TOWN COLLEGE PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PORTER HICKMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS WALLACE H. ADKINSON, 4020 LYONS CREEK RD. DUNKIRK MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-4-1987 to 1-4-1987 , that (I) (we) lost saw the deceased alive on 1-4-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. M. DiN, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-5-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. M. DiN, M.D.		22e. ADDRESS 8510 Kenilworth Ave. Suite # 2600 Riverdale MD 20737					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 8. 1987		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG MD	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, 254 Carroll Rd NW				25a. DATE REC'D. BY REGISTRAR JAN 7 - 1987			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Raines							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED BY MEDICAL EXAMINER TO PMP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It may be placed above carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

16-111-281040

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of", "to", "from" are visible.]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8702790

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Etta Cohen Johnson			2a. DATE OF DEATH MONTH DAY YEAR January 25 1987		2b. HOUR 3:20 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 1 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.	
10. CITY OR TOWN OF DEATH Greenbelt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) proofreader		12b. KIND OF BUSINESS OR INDUSTRY publishing
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY Prince George	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-78-1526		17. INFORMANT ADDRESS Albert F. Johnson same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Villamor S. Reyes</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Villamor S. Reyes, M.D.		22e. ADDRESS 9811 Mallard Dr., Laurel, Md. 20708			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-27-87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan	
23d. LOCATION (CITY OR TOWN) Alexandria Fairfax Virginia		23e. LOCATION (CITY OR TOWN) Alexandria Fairfax Virginia			
24. FUNERAL DIRECTOR Donald V. Borgwardt		4400 Powder Mill Rd Beltsville Md 20705		25. PREPARED BY REGISTRAR FEB 04 1987	
26. REGISTRAR'S SIGNATURE Julia Dindon-Rodack					

BP



3

Jan 2nd 1900

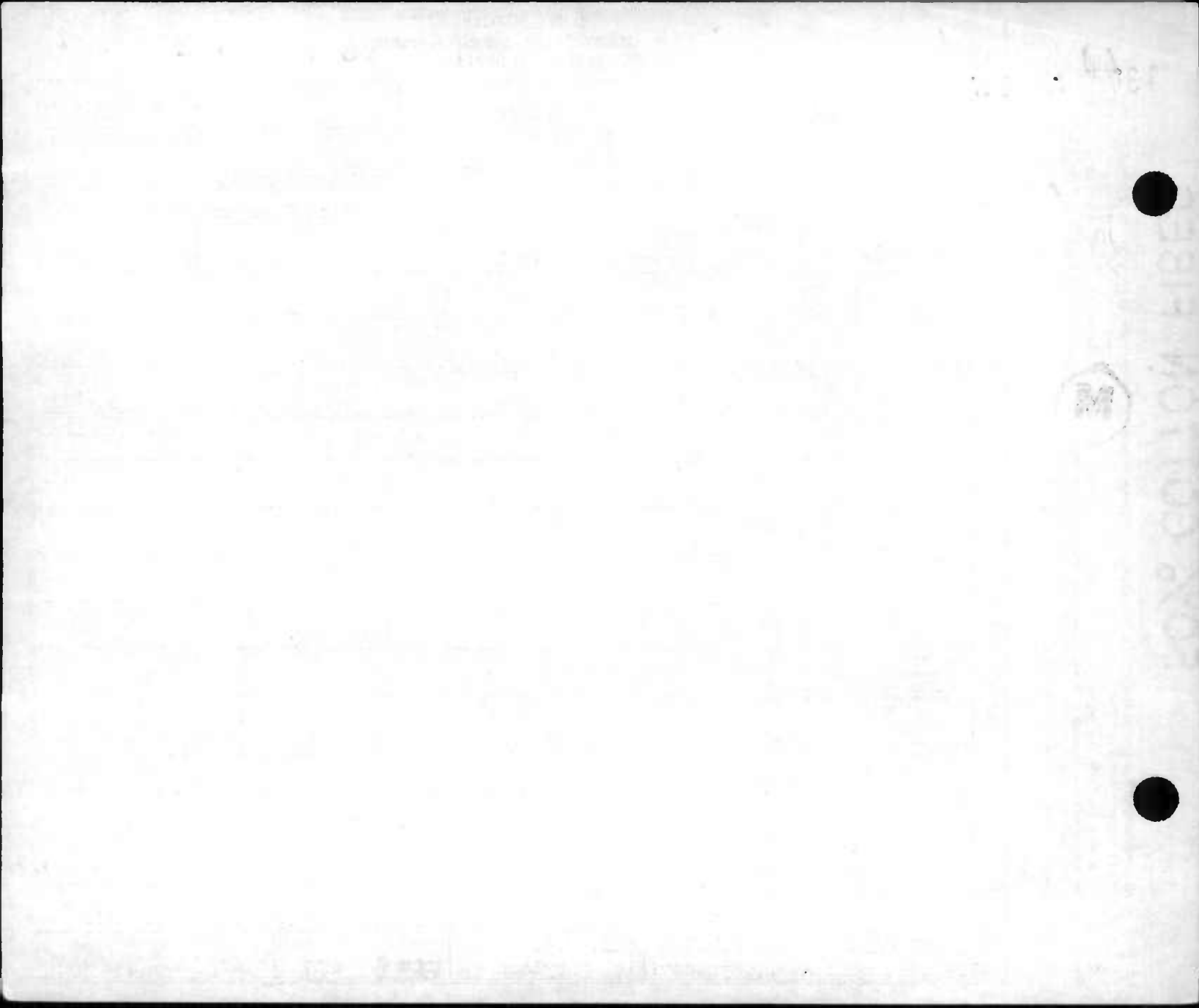
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02191

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	A M
Virginia Margaret Johnson					1		31	87		10:24	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	Caucasian		June 23, 1906		80		YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Virginia	U.S.A.				Prince Georges County		MD.				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Riverdale	Leland Memorial Hospital		Film Developer		Peoples STORE						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland	Prince Geo.	Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5805 42nd Avenue, 20781					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Otis E. Allen		Blanch M. Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No		578-09-7742		9108 Marcellas Drive Harry A. Poss, Owens, Maryland 20736							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Inferior wall M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute pulmonary arrest.</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>o</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <u>Jan 20, 1987</u> to <u>Jan 31, 1987</u> , that (b) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
<u>Padmaja UDAPE M.D.</u>						1/31/87.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
PADMAJA UDAPE M.D.		6005. LANDOVER RD. CHEVERLY MD 20785									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		2-3-87		Gate of Heaven Cem.		Silver Spring, Mont., Md.					
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANK'S GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				FEB 6 1987		<u>John S. S. S.</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then make separate copies of the certificate and pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

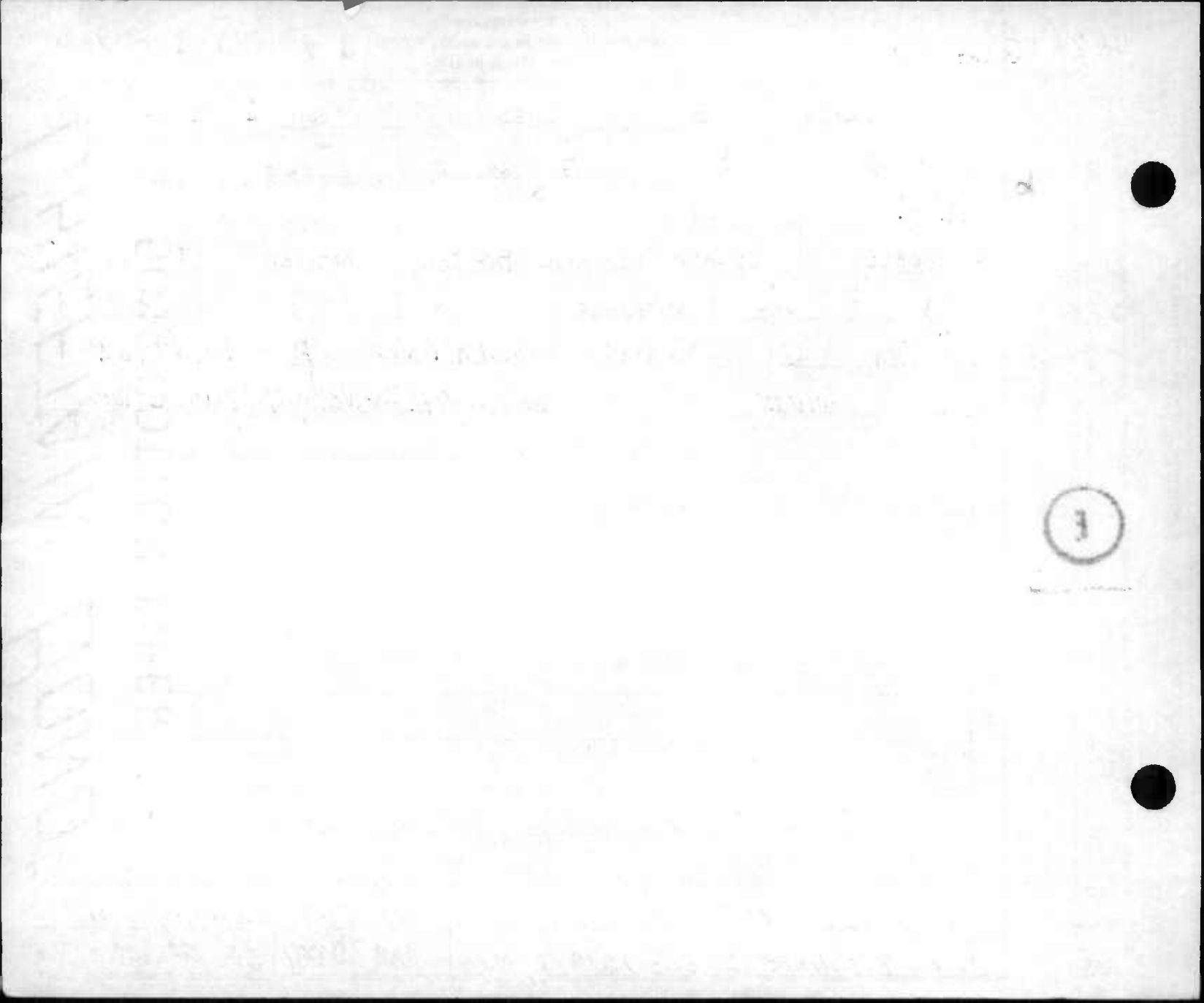
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02 / 98

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HORACE E JONES			2a. DATE OF DEATH MONTH DAY YEAR (Jan) 1 20 87		2b. HOUR 5.19 AM
3. SEX MALE	4. RACE B.	5. DATE OF BIRTH MONTH DAY YEAR 7 23 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G. Co., MD.
10. CITY OR TOWN OF DEATH RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY 3-Wheel Display
13a. STATE MD.	13b. COUNTY PG.	13c. CITY OR TOWN RIVERDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5008 RAVENSWOOD RD. / 20737	
14. FATHER'S NAME FIRST MIDDLE LAST William D. Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERALDINE P. DRAYTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 130-05-6821		17. INFORMANT ADDRESS Dorothy H. Jones / wife / SAME AS 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) URINARY TRACT INFECTION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: QUADRIPLAGIA SECONDARY TO CERVICAL CORD COMPRESSION					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/10 19 86 to 11 19 87 , that (I) (we) lost the deceased above on 11/20 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Tipaporn Woodward		DEGREE M.D.		22c. DATE SIGNED 11/21/87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIPAPORN WOODWARD		22e. ADDRESS 5530 WISCONSIN AVE. #550 CHEVY CHASE, MD 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-23-87	23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VOT.		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM, MD.	
24. FUNERAL DIRECTOR NAME JOHN T. RHINES		ADDRESS 3015-12th ST. N.E.		25a. DATE REC'D. BY REGISTRAR JAN 29 1987	
		25b. REGISTRAR'S SIGNATURE Julia B. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with 72 hours after death with the State Dept. of Health and Mental Hygiene (page 3); cremation, or removal IMPORTANT: If item 21 is marked as item 18, show any injury or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8702199
REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME FIRST RAYMOND MIDDLE L. LAST KEENEY		2a. DATE OF DEATH MONTH JAN DAY 14 YEAR 1987		2b. HOUR 5:45 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH OCT DAY 23 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRESIDENTIAL WOODS HEALTH CARE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY FUEL & FEED	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN CLARKSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Howard MIDDLE - LAST Keeney		15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE - LAST Young		16. SOCIAL SECURITY NO. 220-07-6124		17. INFORMANT ADDRESS Mildred C. Keeney Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ASCD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 yrs		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ASCD			
19a. DATE OF OPERATION 5		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from JAN 7 19 86 to JAN 14 19 87 that (I/we) lost view the deceased on JAN 7 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE Jeffrey		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/14/87	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY		22g. ADDRESS KELMAN MD 6715 BELLEVIEW RD, Hyattsville, Md 20785					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Jan. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Germantown Baptist		23d. LOCATION CITY OR TOWN COUNTY STATE Germantown Mont. Md.	
24. FUNERAL DIRECTOR NAME Muriel H. Barber ADDRESS Laytonsville, Md. 20879		25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

1912 FEB 14

1912 FEB 14



RECEIVED
FEB 14 1912
1912 FEB 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or file.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 8 0 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY M. KEITT			2a. DATE OF DEATH MONTH DAY YEAR 01 15 87			2b. HOUR 10 20 PM					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12-18-33		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY John T. Rhines Co.			
13a. STATE Md.			13b. COUNTY PG		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7729 Greymont St. 20785		
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Massey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Lee Thomas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No			16b. SOCIAL SECURITY NO. 579-50-9631			17. INFORMANT ADDRESS Ms. Doretha M. Keitt/daughter/same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC BREAST CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>URETERAL OBSTRUCTION</u>											
19a. DATE OF OPERATION 1/02/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACTABLE PAIN			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-08</u> , 19 <u>86</u> , to <u>1-15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Radames M. Munoz MD.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/17/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-20-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.			
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20017						25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE Julia Sinden-Randall			

BP

100-10000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 3 0

FOR
- STATE
- REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arthur		FIRST W.		MIDDLE Kelley, Sr.		LAST January 30, 1987		2b. HOUR 6:45 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 10 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk- Ret.		12b. KIND OF BUSINESS OR INDUSTRY Bakers Union	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3115 Brinkley Rd. #202 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Edward Kelley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Scharples					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 039-03-8060		17. INFORMANT ADDRESS Arthur W. Kelley, Jr. 3115 Brinkley Rd. #202 Temple Hills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6:10 , 19 80 , to 1:30 , 19 87 , that (I) (we) last saw the deceased alive on 12/9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H. Nachmani, M.D.				22e. ADDRESS 8926 Woodyard Rd., #601, Clinton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

James M. Kelly, Jr. January 10, 1957

March 10, 1958

March 10, 1958

March 10, 1958

March 10, 1958

March 10, 1958

March 10, 1958

3

March 10, 1958

March 10, 1958

March 10, 1958

040687 JAN 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02802
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACQUES C. KILLINGS		2a. DATE OF DEATH MONTH DAY YEAR 01-05-87		2b. HOUR - 7 40AM M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN. 15, 1949	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICE REP.		12b. KIND OF BUSINESS OR INDUSTRY A.T.&T.			
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN BLADENSBURG	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM (JACK) C. KILLINGS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCRETIA CLAYBOURNE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 256-57-8660		17. INFORMANT HENRY P. ARMWOOD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VARICELLA BULLA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ALCOHOLISM</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS-DAYS YEARS YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 19 87 to 1/5 19 87 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. I was (we) (did not) see the body after death.					
22b. SIGNATURE P. HISSLER MD		DEGREE		22c. DATE SIGNED 1/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7500 GREENWAY CT DR GREENBELT MD 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1-6-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE RECD. BY REGISTRAR JAN 13 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "Kilometer" and "Columbus" are visible.]

41259 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02803

1. DECEASED NAME (TYPE OR PRINT) ANNA MAE KIRBY			2a. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 10 1987			2b. HOUR 17 M		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 25 09	6. AGE IN YEARS (LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 10 1987	2d. HOUR 5 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			10. CITY OR TOWN OF DEATH BIDENSBURG			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5999 EMERSON ST. #609		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.- CLERK			12b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.			13a. STATE MD		
13b. COUNTY PRINCE GEORGE'S			13c. CITY OR TOWN BIDENSBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 5999 EMERSON ST #609			14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN BURTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE McCANN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-18-8081			17. INFORMANT ADDRESS PATRICIA JOHNSON 1300 SPRINGTIDE, PL. HERNDON, VA, 22070		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE LUNG DISEASE								
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) none		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Paul A. DeVore, MD			TITLE (SPECIFY) Deputy			DATE SIGNED 1/10/87		
EXAMINER'S NAME (TYPE OR PRINT) PAUL A. DEVORE, MD			ADDRESS 4203 GREENSBURY HIGHTOWNE MD 20781					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-14-1987			23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		
23d. LOCATION CITY OR TOWN BRENTWOOD, P.G.C. Md.			23e. DATE REC'D. BY REGISTRAR JAN 16 1987			23f. REGISTRAR'S SIGNATURE Julia Swickard-Randall		
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. RIVERDALE, Md. 20737								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

127-1001

93811 NOTION 20% COTTON



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042608 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8702804

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marian Gloria Knight			2a. DATE OF DEATH MONTH DAY YEAR January 27, 1987		2b. HOUR 4:50P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2/2/1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Beltsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Cahsis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Apanovich		13e. STREET ADDRESS / ZIP CODE 9479 Muirkirk Rd., 20708	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-22-5160		17. INFORMANT ADDRESS Joseph G. Knight, Sr. Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO INTESTINAL BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS OF LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANEMIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PNEUMONIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> 19 <u>87</u> to <u>1/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/28/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. SVDHA BAR MD</u>		22e. ADDRESS <u>3626 NEW HAMPSHIRE AVE #212</u> <u>CANOEY PARK MD 20783</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/30/87		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc. Catonsville, Balto., Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Md.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR NAME 237 E. Patapsco Ave., McCully Funeral Homes Balto. Md. 21225					

BP

68/30/1
25/10/2019 20:14:29 - 2019 10/20/2019 20:14:29
25/10/2019 20:14:29 - 2019 10/20/2019 20:14:29

Medical Examiner Notified - Released to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02805

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Athena J. LAMBROS			2a. DATE OF DEATH MONTH DAY YEAR January 13, 1987		2b. HOUR 1:57P M
3. SEX female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 14 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland	13b. COUNTY Prince Georges Riverdale	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5401 Taylor Rd. 20737	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Xydas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Argyro Gatanos			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-10-6751	17. INFORMANT brother Steve Xydas ADDRESS 7716 Riggs Road Hyattsville, Maryland 20783			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Rectal bleeding. S/P colon resection for cancer					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 10 1987 to JAN 13 1987 , that (I) (we) lost saw the deceased alive on JAN 13 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ZLK Zbn MD.		DEGREE		22c. DATE SIGNED 1/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YEAR-KWON H. YOON MD.		22e. ADDRESS 5506 Kenickworth Ave #105 RIVERDALE MD 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 16, 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR JAN 20 1987			
500 University Blvd. West, Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <i>Julius [Signature]</i>			

4
043427 FEB-90

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please indicate on page 3 the date, time, and place of burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 02800

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY Joseph LANGLEY			2a. DATE OF DEATH MONTH DAY YEAR 1-26-87		2b. HOUR P.M. 4 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 24, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 58	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO MD		
10. CITY OR TOWN OF DEATH CHINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Charles White Plains	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 394, Willetts Cro. 20695	
14. FATHER'S NAME FIRST MIDDLE LAST Robert T. Langley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Lucas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-48-0228		17. INFORMANT ADDRESS Blanche Hazel Langley-Sameas #13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PAGE'S DISEASE CARCINOMA OF KIDNEY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-25-87 to 1-26-87 , that (I) (we) last saw the deceased alive on 1-25-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE RS Sany		DEGREE MDFACC		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ. SAMTANI MDFACC		22e. ADDRESS 7801 SURREATIS RD CLINTON MD			
22c. DATE SIGNED 1-27-87					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/30/87	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (CITY OR TOWN) COUNTY STATE Bryantown, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., La Plata, Md.		25a. DATE REC'D. BY REGISTRAR FEB 03 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

1

1. The first meeting of the Board of Directors of the Maryland

of the Maryland Board of Directors, Inc., was held on

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be ascertained that the death was not caused by the event.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna ^{1ST} Lee ^{MIDDLE} Larson ^{LAST} EDNA Lee LARSON		2a. DATE OF DEATH MONTH DAY YEAR 1-21-87		2b. HOUR 8:15 P M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Jan 19, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cherrydale, Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE Georges Co MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO MARYLAND Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE Maryland		13b. COUNTY Pr George	13c. CITY OR TOWN Marlow Hts	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ollie M Patton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche M Shreve		16. STREET ADDRESS / ZIP CODE 3940 Bexley Place #418 20746	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sharon Lanier 3225 Swann Road #303 Suitland, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCAER OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause -last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 1/19 , 19 87 , to 1/21 , 19 87 , that (we) lost saw the deceased alive on 1/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.					
22b. SIGNATURE PHILIP Wisnitsky MD		DEGREE MD		22c. DATE SIGNED 1/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 6188 OXON HILL Rd. - OXON HILL MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 24Jan1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		25a. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland Md		25b. REGISTRAR'S SIGNATURE JAN 30 1987 Julia T. [Signature]	

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18a, & 22a., G-624, by Med. STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 02808

1. DECEASED NAME (TYPE OR PRINT) GEORGE Albert LAST			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 3 1987		2b. HOUR M 10BA
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1957	6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Scientist	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST George S. Last		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Wells		12b. KIND OF BUSINESS OR INDUSTRY University of Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes-Marines		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Peacetime		17. INFORMANT ADDRESS Elizabeth Last (Wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia during routine dental extraction DUE TO, OR AS A CONSEQUENCE OF for impacted molar (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Charles P. Kokes		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 1-4-87	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/10/87		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cemetery	
24. PLACE OF RECORDING Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, MD. 20781		23d. LOCATION CITY OR TOWN COUNTY STATE Olmstead Falls Ohio		25a. DATE REC'D. BY REGISTRAR JAN 13 1987	
25b. REGISTRAR'S SIGNATURE John William...					

07/84
25M
BP 459
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

2002 JUL 10 11:00 AM
CHIEF OF POLICE



1000 1000 1000

043281

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02809

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			MONTH			DAY			YEAR			7b. HOUR								
Chang			Sae			Lee						X			1/28			19			87			M								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD			MONTH			DAY			YEAR			7d. HOUR		
Male			Oriental			May 13, 1906			80			YRS.									1/28			19			87			10:10 P.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			X			NEVER MARRIED			WIDOWED			DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Korea			Korea			X															Montgomery County											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY																							
Takoma Park			8521 Glenview Avenue, #102			Military			Food Supplier for			Food Industry																				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																				
Maryland			Montgomery			Takoma Park			YES			NO			8521 Glenview Avenue, #102																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																													
Seung			No			Lee			Chung			Kim																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			4605 Aspen Hill Rd.																							
no			579-96-2827			son			Chong B. Lee			Rockville, Maryland			20853																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																
PART I DEATH WAS CAUSED BY:																																
IMMEDIATE CAUSE (a) Metastatic carcinoma																																
DUE TO, OR AS A CONSEQUENCE OF																																
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																
(b) carcinoma of the esophagus.																																
DUE TO, OR AS A CONSEQUENCE OF																																
(c)																																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																
None																																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																										
None									YES			NO			X																	
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION																	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			P.M.			19			None			STREET			CITY OR TOWN			COUNTY			STATE											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION																										
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			AT WORK			STREET, FACTORY, FARM, ETC.)			STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED																							
John S. Rogers, M.D.			Deputy			1919 Seminary Road			1/29/87																							
EXAMINER'S NAME			ADDRESS			1919 Seminary Road			Silver Spring, Montgomery County, MD																							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY			STATE																	
Burial			Jan. 31, 1987			Parklawn Cemetery			Rockville			Montgomery			Maryland																	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																										
Francis J. Gallins, Jr.			FEB 6 - 1987			John S. Rogers, M.D.																										
500 University Blvd. West, Silver Spring, Md.																																

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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042809 FEB 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or interment. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02810 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva M. Lee					2a. DATE OF DEATH MONTH DAY YEAR January 31 1987					2b. HOUR 11 ¹⁵ A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 14 1900			6. AGE (IN YEARS (LAST BIRTHDAY)) 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charlie W. Hill					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eurah M. Outten					13e. STREET ADDRESS / ZIP CODE 1511 Covington St. Balto. Md. 21230	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 705-09-2711			17. INFORMANT 20784 ADDRESS Peggy S. Lee, 8320 Oliver St. New Carrollton Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio pulmonary Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/31/87	
DUE TO, OR AS A CONSEQUENCE OF (b) (R) = Right (VA = Cerebrovascular Accident)										12/84	
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD = Atherosclerotic Cardiovascular Disease										12/84	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) LOPD, Anemia, Diverticulosis											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from 12/10/84 to 1/31/87, 19____, that (2) I was lost saw the deceased alive on 1/30/87, 19____, and that in my opinion a death occurred on the date and hour and from the causes stated above, (3) I viewed (did not view) the body after death.											
22b. SIGNATURE G.B. Patrick III MD					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.B. Patrick III MD					22e. ADDRESS 4221 Colesville Rd Silver Spring, Md 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/3/1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. Co. Maryland			
24. FUNERAL DIRECTOR NAME Balto. Md. 21230					25a. DATE REC'D. BY REGISTRAR FEB 2 1987			25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			
McCully Funeral Home, 130 E. Fort Ave.											

10-10-10

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10-10-10

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02811

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		26. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. MONTH DAY YEAR		26. 0300 M	
Nellie		1 - 31 - 87			
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Black		10 9 94	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. AGE	
Seneca md.		U.S.A.		92	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9. BALTIMORE CITY OR COUNTY OF DEATH	
Takoma Park		Seventh Day Adventist		Prince Georges MD.	
12a. USUAL RESIDENCE		12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS / ZIP CODE	
Md.		House work		7520 Maple Ave. 20912	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
George		Lucy		16b. SOCIAL SECURITY NO.	
				577-26-4252	
17. INFORMANT		ADDRESS		17. INFORMANT	
		7520 Maple Ave. Md.		Hilda Jordan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac and respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
b) Congestive heart failure & Aspiration pneumonia					
DUE TO, OR AS A CONSEQUENCE OF					
c) Senile Dementia					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/12, 1986, to Jan 30, 1987, that (I) (we) last saw the deceased alive on 8/30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Smith H. Ho		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME		22e. ADDRESS			
SMITH S. Ho, MD		17610 Carroll Ave Takoma Park Md			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-5-87		Arlington National	
24. FUNERAL DIRECTOR		24b. REGISTRAR'S SIGNATURE		24c. DATE REC'D. BY REGISTRAR	
Comet-Hedgcs		Julia Davidson-Randall		FEB 9 1987	

043095 FEB 15

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02812

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace Lewis			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1987		2b. HOUR A M 5:30
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alex Pollack			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Milstein		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 087-18-1545	17. INFORMANT ADDRESS Surelle Gettman, Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 YR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> 19 <u>86</u> to <u>1/31</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Don H. Yablonski</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonski		22e. ADDRESS 10300 Greenbelt Rd, Seabrook, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-2-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing, New York	
24. FUNERAL DIRECTOR NAME I. J. Morris, Inc		25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
46 Greenwich Street, Hempstead, NY 11550					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or called.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official in jurisdiction and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

040686 JAN 11 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02813	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Estella P. Little</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>01 06 87</u>		2b. HOUR <u>64 M</u>			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>01 20 01</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New Jersey</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George</u> MD.					
10. CITY OR TOWN OF DEATH <u>Laurel</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Greater Laurel Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ret-Saleslady</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>P.G.</u>		13c. CITY OR TOWN <u>Hyattsville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>3908 53Rd. Pl. #201 / 20784</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Jacob P. Andrews</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary E. Schofey</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>164-01-6655A</u>		17. INFORMANT <u>Mr. Thomas S. Little</u>				ADDRESS <u>Same as # 13</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Longestime heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN. 19 1986</u> to <u>present</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lucas A. Casas MD</u>						DEGREE		22c. DATE SIGNED <u>1/6/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LUIS A. CASAS MD</u>						22e. ADDRESS <u>14201 LAMAR Pk. Dr. #221 LAMAR MD 20707</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>1-7-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHAMBERS CREMATORY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>RIVERDALE, P.G.C. Md.</u>				
24. FUNERAL DIRECTOR NAME <u>W. W. CHAMBERS CO.</u>						ADDRESS <u>RIVERDALE, Md. 20737</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1987</u>			
						25b. REGISTRAR'S SIGNATURE <u>Julia D. ...</u>					

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197 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02814

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL Aloysius LONG			2a. DATE OF DEATH MONTH DAY YEAR 01-27-87			2b. HOUR 5.15P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 30, 1904			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	

13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5101 Iroquois Street 20740	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Long			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Dougherty			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-09-9026	
17. INFORMANT (Step-Son) Donald L. Byrd			17. ADDRESS 5101 Iroquois Street College Park, Maryland 20740							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic renal failure, Anaemia, Sepsis, Sick Sinus Syndrome</u>			
19a. DATE OF OPERATION 1/2/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sick Sinus Syndrome	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>86</u> , to <u>1/25</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>R. Rustagi</u> DEGREE MD	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI MD	
22e. ADDRESS 6132 Landover Rd, Cheverly MD 20785		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/29/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Borden</u>	

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DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

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041812 JAN 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02815
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret L. Long			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 9:20 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 26, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9560 Muirkirk Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Md.	13b. COUNTY P.G.C.	13c. CITY OR TOWN LAUREL	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9560 MUIRKIRK RD. #202, 20708	
FATHER'S NAME FIRST MIDDLE LAST FRANK WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA STEEPE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 578-34-7851	17. INFORMANT ADDRESS MRS. BONNIE MUTTER (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) METASTASES. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a HYPERTENSION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-24- 19 86 to 1-19- 19 87 , that (I) (we) last saw the deceased alive on 12-10- 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K. JOSEPH MATTHEW	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. JOSEPH MATTHEW		22e. ADDRESS 6510 Kmielworth Ave Riverdale, Md 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-21-1987	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L. CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALT. CO., Md.	25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. RIVERDALE, Md. 20737		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodgers			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REPORT OF VISUAL

NO.

15

DATE OF VISIT

TIME

REPORTED BY

BY

DATE

NAME OF VESSEL

NO. OF CREW

TYPE

LOCATION OF VESSEL

TIME

DATE

REMARKS

REMARKS

REMARKS

REMARKS

(SEE PAGE 10, 11, 12)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02816
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUTH CROSBY TAYLOR LONG		2a. DATE OF DEATH MONTH DAY YEAR January 22 1987		2b. HOUR MIN. 12 05	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9 1906	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		6b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 80	
7a. CITY OR TOWN OF DEATH Lanham		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		8. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
9. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. COUNTY - - -		13c. CITY OR TOWN Washington	
14. FATHER'S NAME FIRST MIDDLE LAST Unavailable		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unavailable		16. SOCIAL SECURITY NO. 577-28-2231	
17. INFORMANT ADDRESS Hwy 925S, Box 321- Waldorf, Md..		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Uro sepsis DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATELY BETWEEN 24 HRS. H. 5 min 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Asthma Alzheimer's Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from September 25 1984 to January 22 1987 that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Jan 22 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE Leon R. Levitsky		DEGREE M.D.		22c. DATE SIGNED January 22, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leon R. Levitsky M.D.		22e. ADDRESS 3503 Perry St. Mt. Rainier, Md. 20712			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo., Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Peterson-Randall	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS P. O. Box 156 Waldorf, Md 20601		25c. DATE REC'D. BY REGISTRAR	

JAN 29 1987

042833 FEB 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02817
REG. NO.

1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARCUS Leroy LUTHER		2a. DATE OF DEATH MONTH DAY YEAR 01-25-87		2b. HOUR 7 05AM M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1915	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S NURSING CARE CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY Oxygen Company			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5313 42nd Avenue 20781			
14. FATHER'S NAME FIRST MIDDLE LAST Larkin H. Luther		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rovirtia Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Marines		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Peacetime 217-14-7153		17. INFORMANT ADDRESS Gladys N. Luther (Wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Natural Causes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Organic Brain Syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 18</u> , 19 <u>86</u> , to <u>Jan 24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JAN. 24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stuart J. Turkowitz</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/25/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Turkowitz		22e. ADDRESS <u>7500 Greenway Ctr.-Dr. Greenbelt, Md. 20770</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/29/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		23e. NAME OF FUNERAL HOME H. G. Gosh's Sons Funeral Home, P.A.			
23f. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781		23g. DATE REC'D. BY REGISTRAR FEB 3 1987		23h. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Section 2

Section 2

Section 2

Section 2

Section 2

040821 JAN 18 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M
BP 465
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. THIS CERTIFICATE IS TO BE FILED WITH THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. THIS CERTIFICATE IS TO BE FILED WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL. TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

18a, & 22a, G-624, 2/2/87 by STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 02818											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH E. LYNCH					2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1 3 19 87		2b. HOUR M 10:25 A.M.				
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11/3/1950	6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 19 87	2d. HOUR M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5409 Quesada Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5409 Quesada Road #2 20737			
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Caldwell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean E. Gillenwater							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-64-5147		17. INFORMANT ADDRESS Cornelius Caldwell Same as Above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertrophic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Charles P. Kokes				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-4-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/7/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince George's, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Frank's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Jan 13 1987			



(Faint, illegible handwritten notes)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02819									
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Patrick LYNCH										2a. DATE OF DEATH MONTH DAY YEAR January 15, 1987				2b. HOUR 4:00A M					
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1913			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73			IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.										
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Gov't.			12b. PROFESSION OR BUSINESS OR COMMUNICATION Communication Commission							
13a. STATE Md.												13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6009 Naval Ave. 20706	
14. FATHER'S NAME FIRST MIDDLE LAST Peter J. Lynch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen M. Connell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			16b. SOCIAL SECURITY NO. 500-18-3777			17. INFORMANT ADDRESS Janet W. Lynch 6009 Naval Ave. Lanham, Md. 20706							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Parkinsonism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 years</u> <u>10 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Alzheimer's Disease</u> <u>8 years</u>																			
19a. DATE OF OPERATION 1-13-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spinal surgery to remove tumor</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW AND WHERE INJURY OCCURRED (NATURE OF INJURY IN ITEM 18; PART I OR PART 2) <u>Aspiration pneumonia</u>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>Jun 19 70</u> to <u>15 Jan 87</u> , that (I) <u>last</u> saw the deceased alive on <u>14 Jan 87</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Thomas G. Maloney M.D.										DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 Jan 87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Maloney, M.D.										22e. ADDRESS 4814 71st Avenue, Hyattsville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/17/87			23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.										
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home										25a. DATE REC'D. BY REGISTRAR JAN 20 1987				25b. REGISTRAR'S SIGNATURE Julia Swanson					
26. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706																			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02820

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BLANCHE A RLENE MACABOY				JAN 03 1987		2:24A _M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	White	Aug. 25, 1926		60 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maine	U.S.A.			Prince Georges MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Camp Spring	Malcolm Grow USAF Med. Ctr.			Tax Cons.		Acct.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Md.	St. Mary's	Leonardtown		Star Rt. Box 72 / 20650			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Kenneth F. Reynolds		Phillis M. Webb					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		28-16-8286		Francis B. Macaboy same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Adenocarcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (a) (this hospital) attended the deceased from <u>28 Oct</u> 19 <u>86</u> to <u>3 Jan</u> 19 <u>87</u> , that (b) (we) lost saw the deceased alive on <u>3 Jan</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L. Heuin</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>3 Jan 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LORR J. HEUM, Capt. USAF, MC</u> <u>531-82-9636 AFSC 8341</u> <u>Malcolm Grow USAF Medical Center</u>				22e. ADDRESS <u>MALCOLM GROW USAF MED CTR ANDREWS AFB MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/7/87m		St. George Catholic		Valley Lee, St. Mary's, Md	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley, Leonardtown, Md.				JAN 9 1987		<u>Julia Anderson-Rodgers</u> <u>Julia Anderson-Rodgers</u>	

10-15-19

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10-15-19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02821

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Thomas Maier, SR.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-19 19 87			2b. HOUR M 87		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 13	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS	IF UNDER 1 YR. MONTHS DAYS YES	IF UNDER 24 HRS. HOURS MIN NO	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-19 19 87		7d. HOUR M 87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORK LIFE) Pressman		12b. KIND OF BUSINESS OR INDUSTRY Printing
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pfister		17. INFORMANT 11305 Hawk Ridge Terrace				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW-2 141-10-8270		17. INFORMANT William Maier, Germantown, Md. 20874				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE

Augusto P. Rodriguez
EXAMINER'S NAME (TYPE OR PRINT) **Augusto P. Rodriguez, M.D.**

TITLE (SPECIFY)
Deputy

MEDICAL EXAMINER

DATE SIGNED **1-19-87**

ADDRESS **5009 Rayburn Ct., Temple Hills, MD**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A.				25a. DATE REC'D. BY REGISTRAR JAN 28 1987			
4739 Baltimore Ave., Hyattsville, Maryland				25b. REGISTRAR'S SIGNATURE <i>Julia Danderson-Randall</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PMA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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2021 COLLEGE HONOR



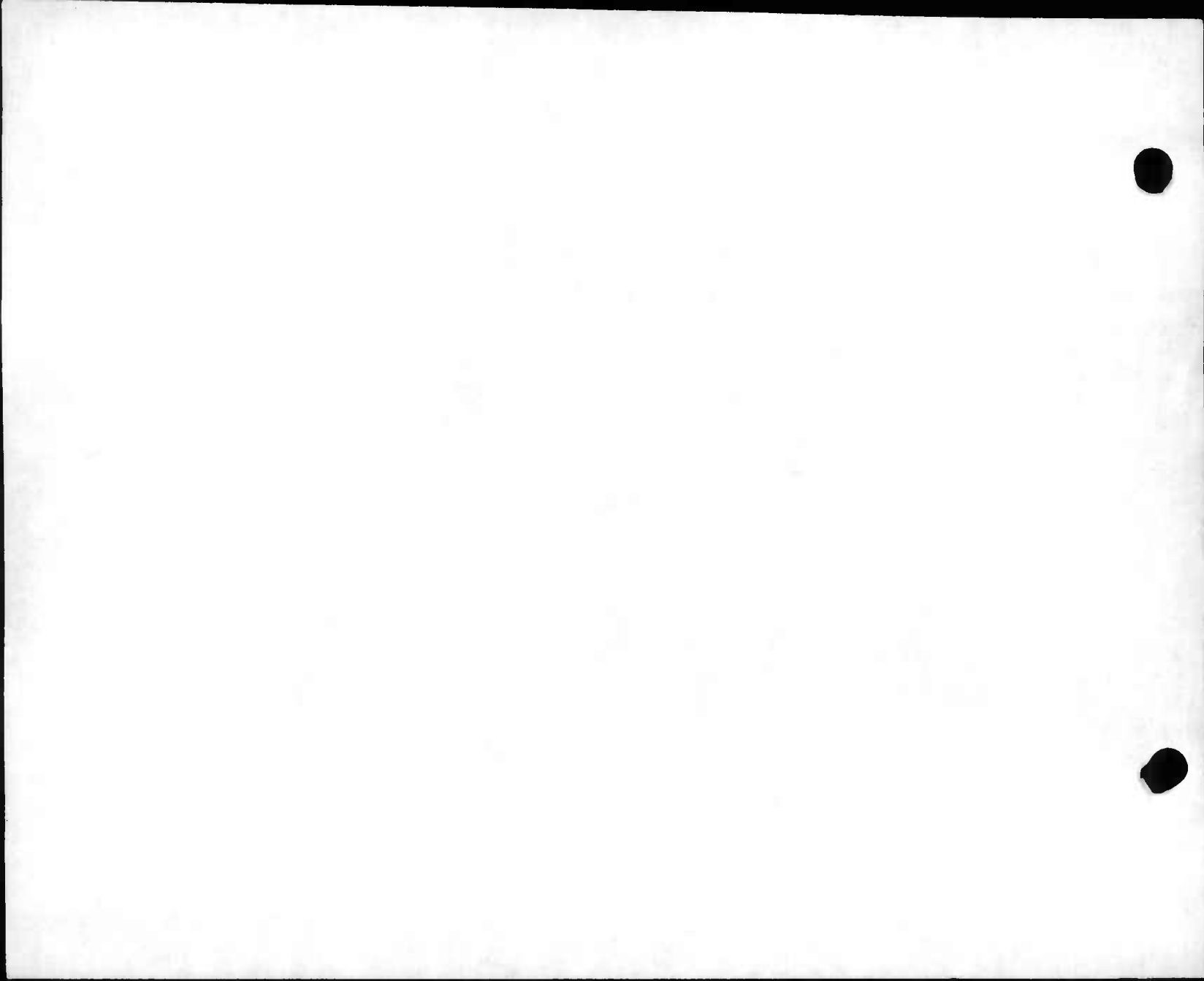
2021 COLLEGE HONOR

Signature

VOIDED DEATH CERTIFICATE NUMBER

87-02822

See 1986 deaths late, Pamela Maria Malcom



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02823

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Theresa M. MANLEY			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1987		2b. HOUR 11:57 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1896		
6. AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. CITY OR TOWN OF DEATH Lanham		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital Of P.G. Co.		11. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Mgr.		12b. KIND OF BUSINESS OR TV Repair		13a. STREET ADDRESS / ZIP CODE 4049 N. 41st. Street 22207		
13b. STATE Virginia		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Gerolomo Baietti		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Barini		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 058-52-8220		17. INFORMANT Leroy J. Haugh		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction of Aorta</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombotic Coronary Artery Disease</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Aneurysm</u>						
19a. DATE OF OPERATION 1-29-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Myocardial Aneurysm of Aorta</u>		20a. AUTOPSY? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>1-29-87</u> 19 <u>87</u> , to <u>1-29</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 1-30-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRO D. MONTANEZ MD		22e. ADDRESS 3308 Doolittle Rd. - Lanham MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Woodside New York		24. FUNERAL DIRECTOR'S NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706				
25a. DATE REC'D BY REGISTRAR FEB 5 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP
DHMH - 16, 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any entries, other traumatic events the medical examiner must be notified of.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02824

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John G. Mariast			2a. DATE OF DEATH MONTH DAY YEAR 1 15 87			2b. HOUR 11:30A _M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 15 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5021 Temple Hill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Night Watchman		12b. KIND OF BUSINESS OR INDUSTRY P. G. County	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Mariast		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Bogich		13e. STREET ADDRESS / ZIP CODE 5021 Temple Hill Rd. 20748			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT 5021 Temple Hill Rd. Emil Mariast Temple Hills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 YRS 10 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 27, 1984, to NOV. 25, 1986, that (I) (we) last saw the deceased alive on NOV. 25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Bruno Kolega</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bruno Kolega, M.D.				22e. ADDRESS 4400 Stamp Rd. Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/87		23c. NAME OF CEMETERY OR CREMATORY Mount Comfort Cemetery Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.				25a. DATE RECD. BY REGISTRAR JAN 19 1987			

M.E.O. Dr. Rodriguez notified and released

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked anything is shown any injury, or other traumatic event, the medical examiner must be notified at once.

BP

George F. Baker, General Editor, 1915.

1

21

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02825

REG. NO.

1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH E MARSHALL			2a DATE OF DEATH MONTH DAY YEAR 1 6 87		2b HOUR 3:20 AM	
3 SEX MALE		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept 13, 1931		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		
10 CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b KIND OF BUSINESS OR INDUSTRY Concrete Co.			
13a STATE Maryland		13b COUNTY PG		13c CITY OR TOWN Beltsville		
14 FATHER'S NAME FIRST MIDDLE LAST Milton Marshall		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Holland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. Korean 214322298		17 INFORMANT ADDRESS 5313 Brewer, Rd Nellie Marshall, Beltsville, Md 20705		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE RENAL FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>12.17.1986</u> to <u>1.6.1987</u> , that (I) (we) last saw the deceased alive on <u>1.6.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE VP Singh		DEGREE M.D.		22c DATE SIGNED 1.6.87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. P. SINGH		22e ADDRESS 5632 ANNAPOLIS RD #9 BLADENSBURG MD 2071-				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1/10/87		23c NAME OF CEMETERY OR CREMATORY Maryland National Laurel PG Maryland		
24 FUNERAL DIRECTOR NAME E.M. Dudley & Sons Funeral Home		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall		
3200 Rhode Island Ave. Mt Rainier Md						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove causes of death. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows prior injury, or other trauma, notify the medical examiner of the death.

JAN 12 1987

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DHMH - 17

(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02821

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN MASAYKO MASAYKO MARTIN			2a. DATE OF DEATH MONTH DAY YEAR 1 23 87		2b. HOUR 5.45 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07 03 1900		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So Maryland Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Waldorf		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painer		
14. FATHER'S NAME FIRST MIDDLE LAST Unavailable		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unavailable		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 171-16-6460		17. INFORMANT ADDRESS Joann Kirstein, 896 Kennebec St. Pittsburgh, Penn		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Electrolyte Imbalance PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Atherosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/23/87 to 1/23/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE G. H. WATHREW				22c. DATE SIGNED 1/23/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. H. WATHREW				22e. ADDRESS WALDORF, MD 20601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/27/87		23c. NAME OF CEMETERY OR CREMATORY Sunset View Mem. Park		
24. FUNERAL DIRECTOR NAME John Elachko F.H.		23d. LOCATION CITY OR TOWN Verona, Pennsylvania		23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 30 1987 John Kirstein		

BP

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042433 FEB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

02828

REG NO.

1. STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8702828					
2. DECEASED NAME (TYPE OR PRINT)		FIRST MINNIE		MIDDLE ALICE	LAST MARTIN		2a. DATE OF DEATH MONTH DAY YEAR 01 23 87		2b. HOUR 12 00P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 12 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSES AID-RET		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7713 CARROLL AVE 20912			
14. FATHER'S NAME FIRST GREEN MIDDLE LAST ROBERTSON		15. MOTHER'S MAIDEN NAME FIRST HATTIE MIDDLE LAST GOARD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 225-38-6009		17. INFORMANT ADDRESS FRANCES TRULL, 7713 CARROLL AVE. TAK PK MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ORGANIC BRAIN SYNDROME										YEARS	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Artery Disease; Obstructive Lung Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/22/87 to 1/23/87 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) (saw) the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. SCHIFFER MD		22e. ADDRESS 7500 CONVENT ROAD DR GREENBELT MD 20771									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY MARTIN FAMILY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE STUART VIRGINIA					
24. FUNERAL DIRECTOR NAME Takoma Funeral Home		ADDRESS 257 Canal St NW DC		25a. DATE REC'D. BY REGISTRAR JAN 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Roadwell					

041627 JAN 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bonoppers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02827

REG. NO.

FOR
1 - STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE H. LAST MATTHEWS			2a. DATE OF DEATH MONTH 01 DAY 07 YEAR 87		2b. HOUR 2:55 PM
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH 08 DAY 13 YEAR 1899	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Greater Laurel/Beltville Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.	13b. COUNTY Pr. Geo	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 495 8th Street / 20707	
14. FATHER'S NAME FIRST MOSES MIDDLE HALL LAST		15. MOTHER'S MAIDEN NAME FIRST ? MIDDLE HARRIS LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-30-4086	17. INFORMANT Lorraine Thomas (daughter)		ADDRESS SAME AS #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myocardial ischemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 12-31, 1986, to 1-7, 1987, that (ii) (we) last saw the deceased alive on 1-7-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. A. DeLaTorre		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. A. DELA TORRE, MD		22e. ADDRESS 320 Montgomery St. Laurel, Md. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-13-87	23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Pr. Geo, MD
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Washington St. Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR JAN 16 1987	25b. REGISTRAR'S SIGNATURE [Signature]

750140

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or there is heart, lung, injury, or other traumatic event, the medical examiner must be notified at once.

Cleared with Medical Examiner

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02830

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS W. McCOLLUM		2a. DATE OF DEATH MONTH DAY YEAR 1-5-87		2b. HOUR 3:12 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 23 10	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS MONTHS DAYS HOURS MIN.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tax Specialist	
12b. KIND OF BUSINESS OR INDUSTRY I.R.S.		13a. STATE Maryland			
13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET ADDRESS 6519 Adelphi Road 20782		14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Wiler			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Hubbard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 322-38-0512		17. INFORMANT 310 N. Oxford St. #4 Robert B. McCollum Arlington, Va. 22203			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ANEMIA DIABETES MELLITUS					
19a. DATE OF OPERATION Dec 9 1986		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Dec 9 1986 to Jan 5 1987 that (I) (we) saw the deceased alive on Dec 9 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Bernard A. Fitzgerald		DEGREE MD		22c. DATE SIGNED 1-5-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD		22e. ADDRESS 317 UNIVERSITY BLVD EXT, SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY Brentwood Prince George's Md.		24. DATE RECEIVED BY REGISTRAR JAN 10 1987			

BP

040700-001

1-2-47-329

McCallum

1-2-47-329

1-2-47-329

Chloroform
Hydrochloric Acid, 10% Solution

Hydrochloric Acid, 10% Solution

1-2-47-329

1-2-47-329

Hydrochloric Acid, 10% Solution

Hydrochloric Acid, 10% Solution

1-2-47-329

Items, #18a, 21a-22a., G-624, STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02831

1. DECEASED NAME (TYPE OR PRINT) Ann Green McComb			2a. DATE KNOWN OF DEATH ESTIMATED 1/4/1987			2b. HOUR 1:50 P M		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 8 1915	6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 1/4/1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		
10. CITY OR TOWN OF DEATH Fort Washington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9808 Parr Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9808 Parr Ct.		20744		
14. FATHER'S NAME FIRST MIDDLE LAST Albert M. Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Scott Hatfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 157-01-9223		17. INFORMANT ADDRESS Dorothy E. Bodington 807 Buckmaster La. Ft. Washington, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide and Flurazepam Intox. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 4 : MONTH DAY YEAR ? P.M. 1 4 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled exhaust fumes from Auto.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN Prince Georges, STATE 9808 Parr Court, Ft. Washington, Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 1/5/87	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN Clinton, P.G., Maryland		
24. FUNERAL DIRECTOR NAME George P. Kalas		ADDRESS 160 Oxon Hill Rd. Oxon Hill, Md.		DATE RECD. BY JAN 9 1987		FURNISHER'S SIGNATURE		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSPORTATION - DIVISION OF VITAL RECORDS - 401 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25A

DHMH - 17
(VR A15 ME (5))

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10-1-57

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 8 3 2

1- STATE REGISTRAR
2- DECEASED NAME (TYPE OR PRINT) **Brion Lee McCoy**
3- SEX **Male** 4- RACE **White** 5- DATE OF BIRTH **9-24-69** 6- AGE (IN YEARS) **17** YRS. 7- IF UNDER 1 YR. 8- IF UNDER 24 HRS. 9- DATE KNOWN OF DEATH **1-7-87** 10- DATE PRONOUNCED DEAD **1-7-87** 11- BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland** 12- CITIZEN OF WHAT COUNTRY? **U.S.A.** 13- MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 14- BALTIMORE CITY OR COUNTY OF DEATH **Prince George's** 15- CITY OR TOWN OF DEATH **Cheverly** 16- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION **Brinsford General Hospital** 17- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Student** 18- KIND OF BUSINESS OR INDUSTRY **Student** 19- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20- STATE **Maryland** 21- COUNTY **P. G.** 22- CITY OR TOWN **Upper Marlboro** 23- INSIDE CITY LIMITS? **YES** 24- STREET ADDRESS **10105 Quince Apple Ct 20772** 25- FATHER'S NAME **Robert** 26- MOTHER'S MAIDEN NAME **Mary J. Brown** 27- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** 28- SOCIAL SECURITY NO. **219-72-3937** 29- INFORMANT ADDRESS **Robert McCoy Same as 13 A-E**

18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Head injury.**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a- DATE OF OPERATION **1-1-87** 19b- CONDITION FOR WHICH OPERATION WAS PERFORMED? **Cerebral Hemorrhage.** 20- AUTOPSY? **YES** 21a- EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH **1-1-87** 21b- TIME OF INJURY **1:30 P.M. 1-1-87** 21c- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) **Driver auto - fixed object impact** 21d- PLACE OF INJURY (at HOME, STREET, FACTORY, FARM, ETC.) **Street** 21e- LOCATION (CITY OR TOWN, COUNTY, STATE) **Beltsville, Upper Marlboro, Prince Georges Md**

22a- I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ 23a- ACTUAL SIGNATURE **Augusto P. Rodriguez** 23b- TITLE (SPECIFY) **Deputy** 23c- MEDICAL EXAMINER 23d- DATE SIGNED **1-7-87** 23e- EXAMINER'S NAME (TYPE OR PRINT) **Augusto P. Rodriguez, M.D.** 23f- ADDRESS **5009 Rayburn Ct., Temple Hills, Md**

23a- BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b- DATE **01/12/87** 23c- NAME OF CEMETERY OR CREMATORY **Trinity Episcopal Cemetery** 23d- LOCATION (CITY OR TOWN, COUNTY, STATE) **Upper Marlboro P. G. Md.** 24- FUNERAL DIRECTOR NAME **Lee Funeral Home, Inc.** 25a- DATE REC'D. BY REGISTRAR **JAN 16 1987** 25b- REGISTRAR'S SIGNATURE **Julius Sanders-Rodner** 26- ADDRESS **6633 Old Alexander Ferry Rd Clinton, Md 20735**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

RECEIVED

11/15

RECEIVED

11/15

11/15

11/15



1

11/15

041909 JAN 28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02833

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances C. McCollum			2a. DATE OF DEATH MONTH DAY YEAR Jan. 20, 87		2b. HOUR 5:30 A.M.	
3. SEX F		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 4 24 99		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn-		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY City of Greenbelt
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Michael Callahan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Dickson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579126571A
17. INFORMANT John E. McCollum		ADDRESS P.O. Box 403 Springfield, Va.		22150		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 19 85 to Jan 19 87 , that (I) (we) lost saw the deceased alive on Jan 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b. SIGNATURE Ma Dobson		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ma Dobson		22e. ADDRESS 8157 Lakecrest Dr Greenbelt Md 20770				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1-22-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P. G. Md.
24. FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd. Beltsville Md. 20705				25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation is required.

04100 00140

0 5 0

Jan 22, 1971

The Callaway

PP 45 K

Home Goods

Gen

Wash

Gen

Grandview Nursing Center

Grandview

04100 00140

The following is a list of the items received from the Grandview Nursing Center on January 22, 1971.

1. 100 lbs. of white laundry soap
2. 100 lbs. of white laundry soap
3. 100 lbs. of white laundry soap
4. 100 lbs. of white laundry soap
5. 100 lbs. of white laundry soap
6. 100 lbs. of white laundry soap
7. 100 lbs. of white laundry soap
8. 100 lbs. of white laundry soap
9. 100 lbs. of white laundry soap
10. 100 lbs. of white laundry soap

Grandview Nursing Center

Jan 22, 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02834

1. DECEASED NAME (TYPE OR PRINT) FRED		FIRST MIDDLE LAST MCDANIEL		2a. DATE OF DEATH MONTH DAY YEAR 1 6 87		2b. HOUR 12:20 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 02 16		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Washington		13b. COUNTY D.C.		13c. CITY OR TOWN N.W.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1946 579-12-3508	
17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Wegester Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/19 1986 to 1/6 1987, that (I) (we) lost saw the deceased alive on 1/6 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Mostaan		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REZA MOSTAAN, M. D.		22e. ADDRESS 4235 28th Avenue Temple Hills, MD. 20748					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-13-1987		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland	
24. FUNERAL DIRECTOR NAME Robert G. Mason		ADDRESS 1661 Grand Hope Rd. SE		25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

100-100-100

PAVEMENT

20% CRACKS

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043282 FEB 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02835

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret E. McGill			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1987			2b. HOUR MIN. 3:22p.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges			MD		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9902 Wildwood Road 20895	
14. FATHER'S NAME FIRST MIDDLE LAST Bartholomew F. Finn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Nora Byrne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 577-10-5005		17. INFORMANT ADDRESS William E. McGill Son Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebrovascular Disease Dementia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/31/87 to 1/31/87 , that (I) (we) lost saw the deceased alive on 1/31/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. M. Khatra						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IBRAHIM M. KHATRA						22e. ADDRESS 6525 Belcrest Rd. Hyattsville MD. 20782					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.						25a. DATE REC'D. BY REGISTRAR FEB 6 1987			25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall		
500 University Blvd., W. Silver Spring, Md.											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

43426 FEB-90

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02836

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLETCHER McMillan			2a. DATE OF DEATH MONTH DAY YEAR 1-20-87		2b. HOUR 2-20P						
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11-11-14		6. AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.					
10. CITY OR TOWN OF DEATH CHANTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE			
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN TEMPLE HILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4021 LYONS ST. 20748			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE McMillian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES PATRICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 249-09-4667		17. INFORMANT ADDRESS ESTELLA V. DRAFT- 4021 LYONS ST.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF Probable MYOCARDIAL INFARCT	
DUE TO, OR AS A CONSEQUENCE OF Septic Shock			

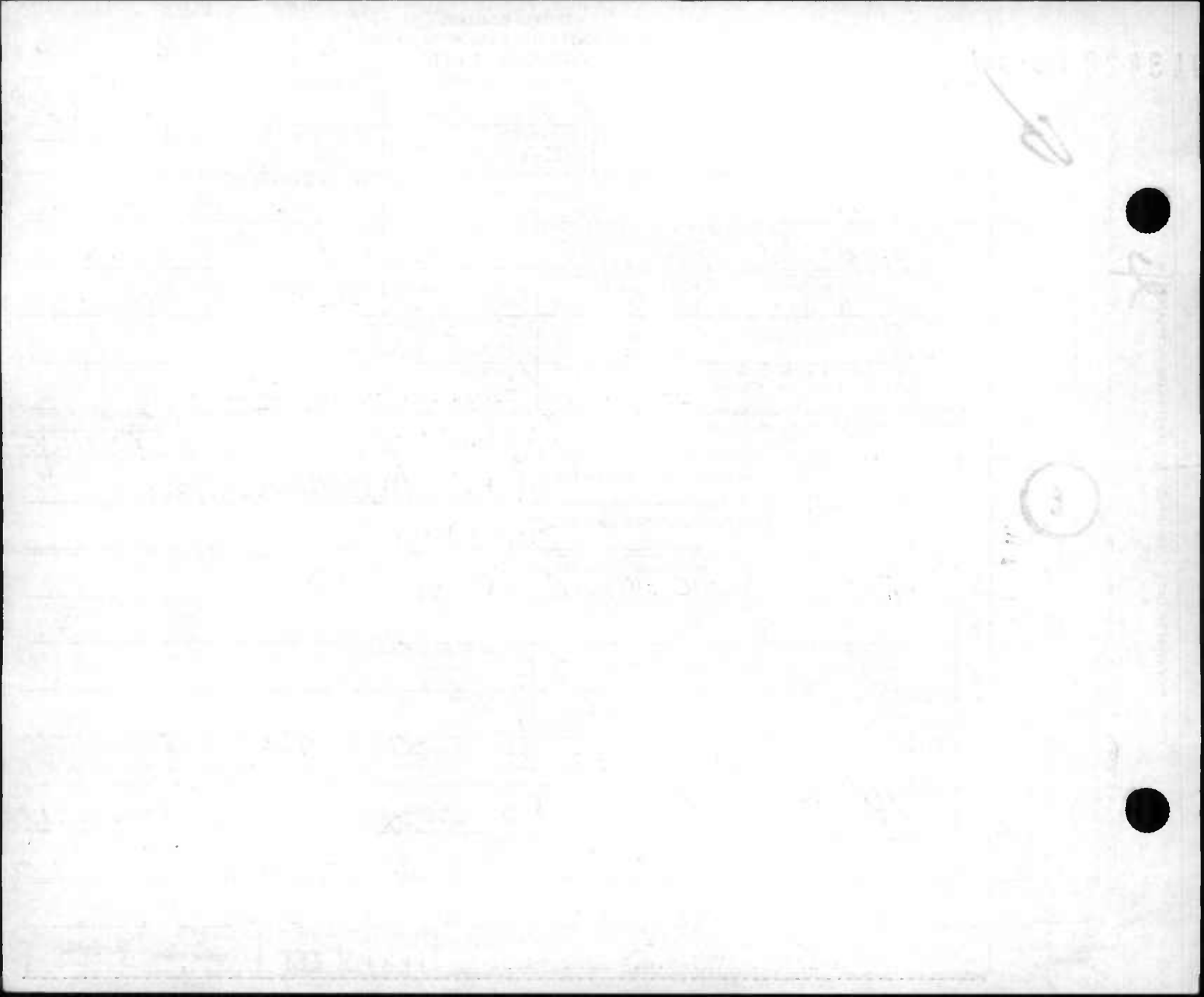
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes, Chronic Steroid Therapy, COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/10 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1110 87 1/20 87			
22a. I certify that (I) (this hospital) attended the deceased from 1/20 87 to 1/20 87 , that (I) (we) last saw the deceased alive on 1/20 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael Levine		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JANUARY 21, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Levine		22e. ADDRESS 7801 BRANTON AVE. CLINTON MD 20735					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-24-87		23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, M.D.	
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE				25a. DATE REC'D. BY REGISTRAR FEB 03 1987		25b. REGISTRAR'S SIGNATURE Juan Davidson-Rodriguez	
26. ADDRESS 2617 PA. AVE. S.E.-WASH., D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02837
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (PRINT) Celia MELINK		2a. DATE OF DEATH MONTH DAY YEAR January 18, 1987		2b. HOUR 7:14a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 21, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hotel-Kitchen Wk	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Prince-Georges	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Steven Bordon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Bourgo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 472-32-0762	17. INFORMANT ADDRESS JOHN V. MELINK, 6465 GUINEA PIKE, LOVELAND, OHIO		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)
DUE TO, OR AS A CONSEQUENCE OF		(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-8-78, 19, to 1-18-87, 19, that (I) (we) last saw the deceased alive on 1-15-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>John Kehoe</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN KEHOE	22e. ADDRESS 6300 RIVERDALE RD RIVERDALE MD 20840		

23a. BURIAL, CREMATION, REMOVAL (PRINT) Burial	23b. DATE Jan 22, 1987	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery	23d. LOCATION (CITY OR TOWN) COUNTY STATE Hunting Minnesota
24. FUNERAL DIRECTOR NAME Takima Funeral Home, J. J. Jettico, 254 Carroll St NW DC		25. DATE REC'D. BY REGISTRAR JAN 27 1987	
		25b. REGISTRAR'S SIGNATURE Julia E. Jettico	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

040680 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7	0	2	8	3	8		
1. FOR REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Raymond Miller										2b. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 1-10 1987 2d HOUR M							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-16-1906		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-10 1987 2d HOUR M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.							
10. CITY OR TOWN OF DEATH Fort Washington				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8105 Comet Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer				12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. STATE Maryland										13b. COUNTY P.G.		13c. CITY OR TOWN Fort Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8105 Comet Drive	
14. FATHER'S NAME FIRST MIDDLE LAST James W. Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Kanipe												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 579-05-0150					17. INFORMANT Fort Washington Md. 20744 Raymond E. Miller 3611 Oakmont Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interventricular conduction system disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Status post colostomy 1 1/2 year, colon cancer</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TIME (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 1-10-87					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 5709 Rayburn Ct. Cap Spr. Pr. Gees Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-12-1987				23c. NAME OF CEMETERY OR CREMATORY National Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Fiffrax Virginia					
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR JAN 13 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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100-100000

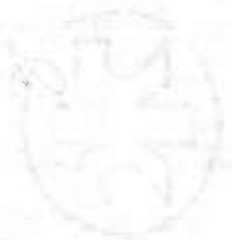
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02839

REG. NO.

FOR
1. STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MARGARET M. THILLAR

2a. DATE OF DEATH MONTH DAY YEAR 1-31-87 2b. HOUR 825 A M

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR 9-24-1882

6. AGE (IN YEARS LAST BIRTHDAY)

104

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Michigan

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Southern Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Cashier

12b. KIND OF BUSINESS OR INDUSTRY

Department Store

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince George's

13c. CITY OR TOWN

Upper Marlboro

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

9115 Marlboro Pike L-29 20772

14. FATHER'S NAME

John

MIDDLE

MacDonald

15. MOTHER'S MAIDEN NAME

Jessie

MIDDLE

McGillvary

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

470-01-6979

17. INFORMANT

Beryl Drury

ADDRESS

9116 Marlboro Pike L-29

Upper Marlboro, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROSIS

YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from SEPT 19 83, to 1/31 19 87, that (I) (most) saw the deceased alive on 1/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

M.W. 2m

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

1/31/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

PHILIP WISOTSKY M.D.

22e. ADDRESS

6188 Oxon Hill Rd. OXON HILL MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

2/4/87

23c. NAME OF CEMETERY OR CREMATORY

Oneota Cemetery

23d. LOCATION

Duluth

COUNTY

St. Louis

STATE

Minn.

24. FUNERAL DIRECTOR

NAME

George P. Kalas Funeral Home Oxon Hill, Md.

6160 Oxon Hill Rd.

25a. DATE OF DEATH BY REGISTRAR

FEB 3 1987

25b. REGISTRAR'S SIGNATURE

A. A. Anderson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

10% COTTON FIBRE

①

some of the most common types of cotton fibre
and are used in the manufacture of cotton
textiles. The cotton fibre is a natural
product of the cotton plant and is
composed of cellulose and lignin. The
cotton fibre is a long, thin, and
flexible strand that is composed of
many small cells. The cotton fibre is
a natural product of the cotton plant
and is composed of cellulose and lignin.

042294 JAN 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

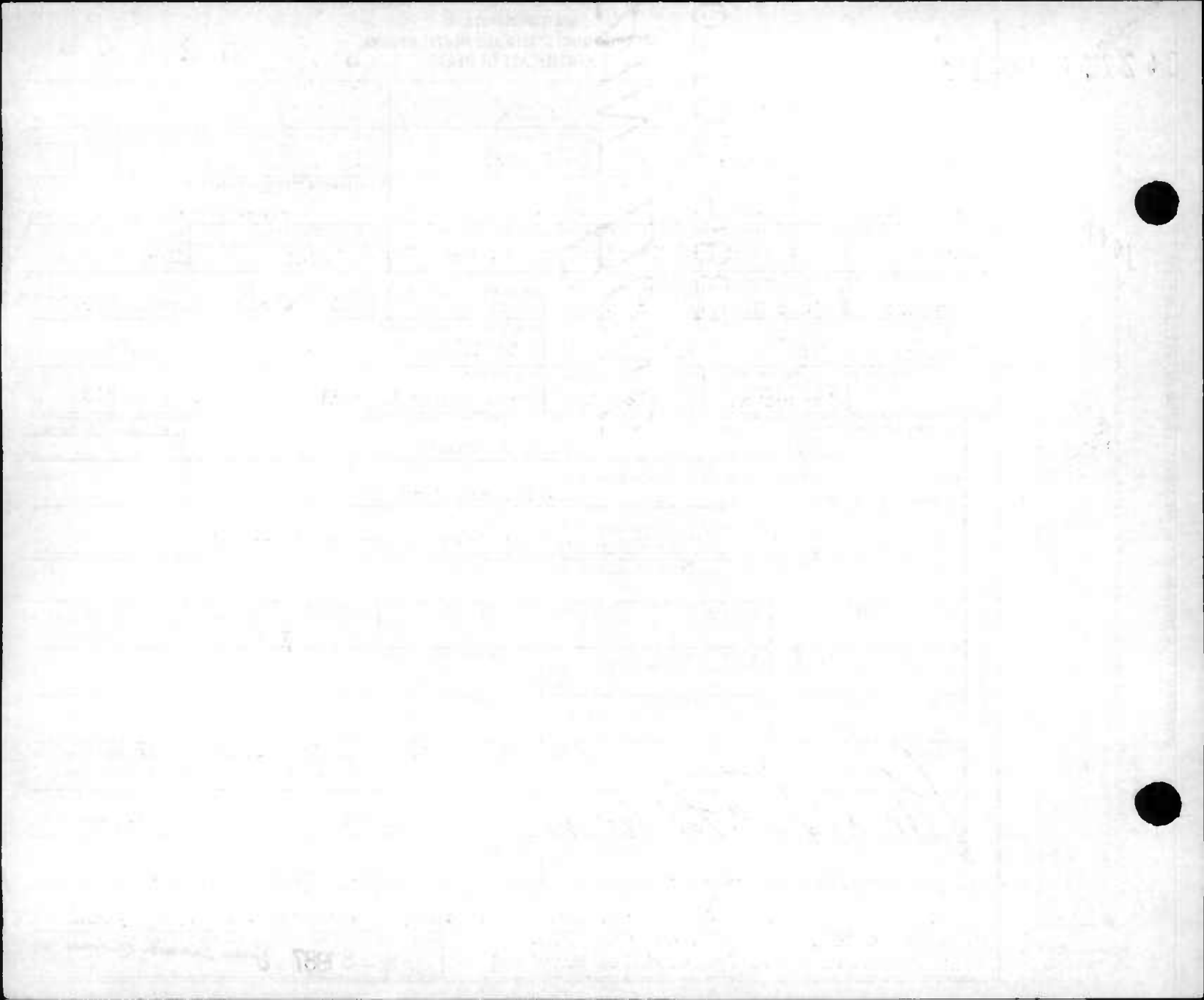
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02840

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
WILLIAM THOMAS MILLER			JANUARY 16 1987			1:28P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	9-23-1929	57			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash. D.C.	U.S.A.		Prince George's MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' Hospital of Pr. Geo. Co.		Technician			Electronics		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
Maryland			Prince Geo.	E. Riverdale	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6623 Powhatan Street 20737		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Richard T. Miller			Lillian Mae Dodd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes			Peacetime			Mrs. Nancy L. Miller, Same as Line #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrest								
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c) Massive Abdominal Carcinomatosis, Terminal								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 3, 1987, to January 16, 1987, that (I) (we) last saw the deceased alive on January 16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Jamshid Taheri, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/16/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Jamshid Taheri, M.D.						3710 Raviera St. Marlow Hgts. Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
Burial			1-19-87	Ft. Lincoln Cemetery			Brentwood, P.G., Maryland	
24. FRANCHISE GASCH'S SONS FUNERAL HOME, P.A.						25a. DATE REC'D. BY REGISTRAR		
4739 Baltimore Ave., Hyattsville, Maryland						JAN 28 1987		



42580 FEB-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02841

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
3. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Dec 9 1948		38 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		USA				Prince George MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Mitchellsville		2005 Hideout Lane		Horticultorist		Gardening	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		N.P.G.		Mitchellville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Paul T. Minno		Cezudia J. Merayd		Yes		160-42-8186	
17. INFORMANT		ADDRESS		17a. DATE OF OPERATION		17b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Maurice P. Minno		1816 Breton Ct. Reston, Va. 22091					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acquired Immune Deficiency Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19							
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE							
22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)							
22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)							
23b. DATE							
23c. NAME OF CEMETERY OR CREMATORY							
23d. LOCATION CITY OR TOWN							
24. FUNERAL DIRECTOR NAME							
25a. DATE RECEIVED BY REGISTRAR							
25b. DATE RECEIVED BY REGISTRAR							

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

SECRET

[Faint, illegible handwritten text covering the majority of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02842

1. STATE REGISTRAR										
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frances R. Mondi</i>										
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH (MONTH DAY YEAR) <i>April 27 1913</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>73</i>		7a. DATE KNOWN OF DEATH ESTI- MATED <i>Jan 6 1987</i>		7b. HOUR <i>4:30</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Anita, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>		10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital Center</i>
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr George</i>		13c. CITY OR TOWN <i>Forestville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dominic Mondi</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>209 01 8429</i>		17. INFORMANT <i>2311 Pimmit Drive #607 Falls Church Va</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cervical vertebral fracture + subluxation: Deterioration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Liver cirrhosis and arthritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12-31 1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>felt dizzy & fell</i>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION CITY OR TOWN COUNTY STATE <i>2020 Brooks Drive #8, Forestville, Pr George, Md</i>		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		22c. TITLE (SPECIFY) <i>Deputy</i>
22d. ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		22e. EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		22f. ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md</i>		22g. DATE SIGNED <i>Jan 6, 1987</i>		22h. MEDICAL EXAMINER		22i. DATE REC'D. BY REGISTRAR <i>JAN 14 1987</i>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9 Jan 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont Md</i>		24. FUNERAL PREP. NAME <i>Robert E. Wilhelm Funeral Home</i>		25. REGISTRAR'S SIGNATURE <i>John T. ...</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEMPTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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041863 JAN 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral home must file a notification with the State Dept. of Health and Mental Hygiene.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
FIRST MIDDLE LAST					MONTH DAY YEAR					HOUR MIN.				
1. MAUDE R. Mosteller					January 18, 1987					11:15 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE		7. UNDER 1 YEAR		7. UNDER 24 HRS.			
Female		White		January 27, 1903			83 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince Georges						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY						
Clinton		Pineview Manor Extended Care Center			Housewife			N/A						
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland					Prince George		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8600 Mike Shapiro Dr. 20735			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST					FIRST MIDDLE LAST									
Andrew J. Heffron					Mary Catherine Beach									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT							
No					577-48-6959		Mary E. Fiedler					13306 Cold Water Dr. Ft. Washington, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>old pulmonary Tuberculosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 11a														
<u>Hypertension, Cardiac arrhythmias, Calcific pleuritis, Anemia.</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED								
(IF EITHER, NOTIFY MEDICAL EXAMINER)			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (we) (we) attended the deceased from <u>October 20</u> , 19 <u>86</u> , to <u>January 18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>January 18</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE					DEGREE <u>M.D.</u>					22c. DATE SIGNED				
<u>Massoud NEMATI</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					<u>1/18/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
<u>MASSOUD NEMATI, M.D.</u>					<u>3611 Branch Ave #407, Temple Hills, Md. 20748</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION						
<u>Burial</u>			<u>1/20/87</u>		<u>Cedar Hill Cemetery</u>			<u>Suitland P.G. Maryland</u>						
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>George P. Kalas Funeral Home Oxon Hill, Md.</u>										<u>JAN 27 1987</u>		<u>Julia Dindon-Rodriguez</u>		

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 since any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 02845 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William E. Mothershead					2a. DATE OF DEATH MONTH DAY YEAR 1 15 87		2b. HOUR 7:00 A.M.				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9 7 01		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5503 Hill Way				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Painter			
13a. STATE Maryland					13b. COUNTY Pr. George		13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST H. Settle Mothershead					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary B. Van Ness						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-3393		17. INFORMANT ADDRESS Lydia R. Siegwarth Same as item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Mitral regurgitation DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3611 Branch Ave. Temple Hills, Md. 20748							
22a. I certify that (I) (this hospital) attended the deceased from April 13 19 86 , to January 15 19 87 , that (I) last saw the deceased alive on Dec. 19 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE <i>William J. Oetgen, M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William J. Oetgen, M.D.					22e. ADDRESS 3611 Branch Ave. Temple Hills, Md. 20748						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/87		23c. NAME OF CEMETERY OR CREMATORY Washington Nat. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.					
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.					25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson</i>				

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040706 JAN 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02846
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA JOSEPHINE MULLEN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 2 1987		2b. HOUR 9:40A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 12, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. CITY OR TOWN Seabrook	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Coffey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridgett (unavailable)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-28-6621		17. INFORMANT 9916 East Franklin Ave. Elizabeth A. Lopez, Glen Dale, Md. 20769	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic calcification & occlusion of left</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>anterior descending coronary artery.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> , 19 <u>86</u> , to <u>1/2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <i>M. A. Nandedkar</i>				27c. DATE SIGNED 1-3-87	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. Nandedkar, M.D. Associate Pathologist				27e. ADDRESS Doctors' Hospital, Lanham, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-5-87	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.	
24. FRANCIS CASCH'S SONS FUNERAL HOME, P.A. NAME ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 13 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02841

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST NORMA		MIDDLE Z.		LAST MURPHY		2a. DATE OF DEATH MONTH DAY YEAR 01 25 87		2b. HOUR I:10A ^M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 27 30		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.							
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 4807 Heath Street 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Edwards				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Obtainable									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 579 40 4429		17. INFORMANT James L Murphy				ADDRESS Same as #9			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypothyroidism</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 19 87, to Jan 25, 19 87, that (I) (we) last saw the deceased alive on above (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE <u>Stuart J. Turkewitz</u> MD								DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Turkewitz								22e. ADDRESS 7500 Greenway Ctr. Dr. Greenbelt, Md. 20770.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 29 Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR'S NAME Robert E Wilhelm								ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR FEB 05 1987		25b. REGISTRAR'S SIGNATURE <u>Julia D. [Signature]</u>	

BP _____

THE UNIVERSITY OF CHICAGO
LIBRARY

1937

Chicago, Illinois
September 1937

My dear Mr. [illegible]

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I have just received your letter of the 23rd and am glad to hear from you. I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand my position.

040357 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 0 2 8 4 8
REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JOHN J. MURRAY		2a. DATE OF DEATH MONTH DAY YEAR 01-02-87		2b. HOUR M 2 : 45 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 13, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUDIO TECHNICIAN		12b. KIND OF BUSINESS OR INDUSTRY THEATER			
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2202 QUEENS CHAPEL RD. 20782	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN J. MURRAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET McCADE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-46-3187		17. INFORMANT ADDRESS CAROLE MORELAND (SAME AS ITEM #13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malignant Melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Paraplegia, Urinary Tract Lesions</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>12/10/86</u> to <u>1/2/87</u> that (I) (we) last saw the deceased alive on <u>12/31/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22a. SIGNATURE <u>Robert Ruderman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/3/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT RUDERMAN, M.D.				22e. ADDRESS 6510 KENTILWORTH AVE. SUITE 2100 RIVERDALE, MD. 20737					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1-5-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John E. ...</u>	

BP

JAN 9 1987

TEMPERATURE

100-22040

DATE

CHYON, J. M. 100-22040

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 0 2 8 4 9

1. DECEASED NAME (Type or Print)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
MORRIS L. NACHIMSON				1/10/87		4:45 P.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE	Dec. 7, 1920		66			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York	U.S.A.			PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address)		12a. USUAL OCCUPATION (Type of work for most of working life)		12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON	So. Md. Hosp. CTR.		Mail Carrier		U.S. POST OFFICE		
13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Virginia		Fairfax		Falls Church		13e. STREET ADDRESS / ZIP CODE	
						8004 Chanute Place 99999	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS			
Abraham Nachimson		Mamie Ossipowitz		Vivian Crowley, Daughter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (If yes, give war or dates)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WW II		125-09-2765		8004 Chanute Place, Falls Church, VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Wound & renal failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Parkinsonism & schizophrenia Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/21 1987 to 1/10 1987, that (I) (we) last saw the deceased alive on 1/10 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Mark H. Pillor		M.D.		1/10/87			
22d. PHYSICIAN'S NAME (Type or Print)		22e. ADDRESS					
Mark H. Pillor		6188 Oxon Hill Rd Oxon Hill Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Jan. 15, '87		Calverton Natl. Cemetery		Calverton, New York	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MONEY & KING VIENNA FUNERAL HOME, VIENNA, VA				JAN 19 1987		Julia D. Baker	

1112-1-1001-10

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042105 JAN 29 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02850			
1. DECEASED NAME (TYPE OR PRINT) <i>Lillian Jackson Nesbitt</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>1-5 1987</i>		2b. HOUR <i>M</i>					
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-19-20 1966</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>166</i> YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Montreal, Va.</i>				9. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.			
12. CITY OR TOWN OF DEATH <i>Don Ham</i>				13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9906 Grant Street</i>				14. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) <i>Self Employed</i>		15. KIND OF BUSINESS OR INDUSTRY <i>Federal Govt</i>			
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <i>NO</i> COUNTY <i>Washington DC</i>						16b. CITY OR TOWN <i>Washington DC</i>		16c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16d. STREET ADDRESS <i>55-13 Bass Place SE</i>			
17. FATHER'S NAME FIRST MIDDLE LAST <i>William H. Jackson</i>				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mignon Jones</i>									
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				19b. SOCIAL SECURITY NO. <i>1578 228296</i>				19c. INFORMANT'S ADDRESS <i>John Knott, 9906 Grant St Ma</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Hypertensive Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>1-6-87</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>9 Jan 87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Mem. Bur. Landover, Maryland</i>				23d. EDUCATION (BY OR TOWN) <i>Landover, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>G. Ernest Smith, Inc.</i> ADDRESS <i>1432 You St, N.W.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1987</i>				25b. REGISTRAR'S SIGNATURE <i>John Smith</i>					

1. The first part of the document
describes the general situation
of the country and the
state of the economy.

2. The second part of the document
describes the state of the
economy and the
state of the country.

3. The third part of the document
describes the state of the
country and the
state of the economy.

041506 JAN 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene provided to be signed, embossed, or removed.

IMPORTANT: If item 21 is marked, item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

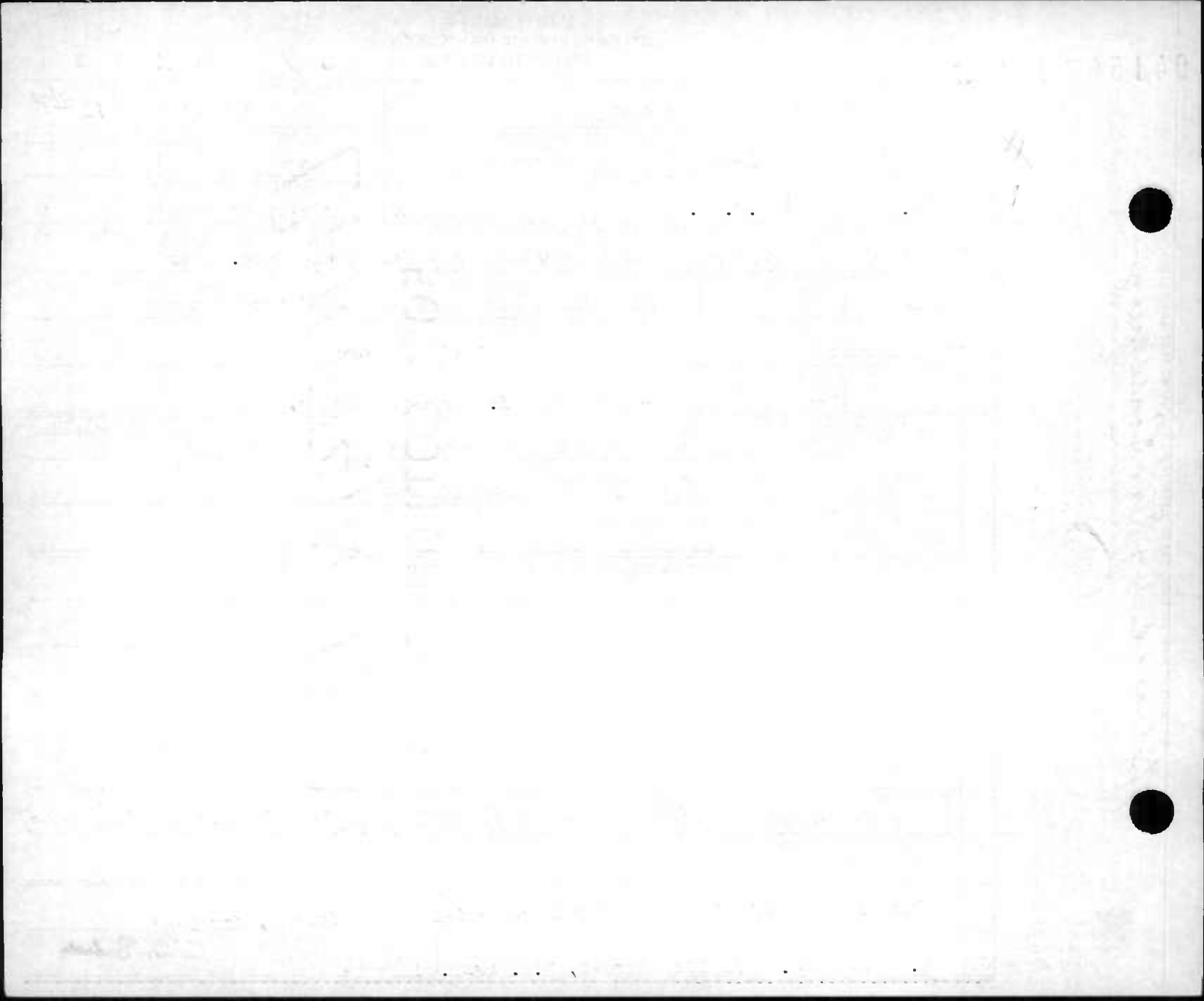
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02851

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Ingrid C. Nicholas				01/14/87		12:47 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
Female	Black	9/23/47		39			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penn.	U.S. A.			Prince George's MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON	SOUTHERN MD. HOSPITAL CENTER		Supply Cont. Spec				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland	PG	Temple Hill		4704 23rd Parkway 20798			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Samuel Carter		Julia Ford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		None 204-38 2769		Miss Arnette Carter,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary embolus</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute bronchopneumonia, H. O. Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1987, to 1/14, 1987, that (I) (we) lost saw the deceased alive on 1/13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Edward S. Sherrer MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>87 Jan 15</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward Sherrer</i>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/20/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>JOHN T. RHINES CO.</i> ADDRESS <i>3015 12th Street, N.E. Wash. DC</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Deborah Randolph</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02852

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH HERMAN NIEBERDING			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5 1987		2b. HOUR 6:40A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 19, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teletype Operator	12b. KIND OF BUSINESS OR INDUSTRY United Press	
13a. STATE Maryland			13b. COUNTY Prince George's	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bernhard Nieberding			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Amrhain		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-03-5958		17. INFORMANT Rose Mary Nieberding Same as Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure. Acute Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery disease. Left ventricular failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis. Abdominal aortic aneurysm.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>82</u> , to <u>1/4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert J. Gerstl</u>				22c. DATE SIGNED 1/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GERSTL				22e. ADDRESS 4410 74th Ave. Landover Hills, MD 20784	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince George's Md.		25a. DATE REC'D. BY REGISTRAR JAN 13 1987			
25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>					



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041163 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02853

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anne E. Norair			2a. DATE OF DEATH MONTH DAY YEAR January 7 1987		2b. HOUR P 9:53 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 11 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's	
10. CITY OR TOWN OF DEATH Landover		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 8509 Hillview Road		12a. USUAL OCCUPATION (OF DECEASED AT WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Noah		15. MOTHER'S MAIDEN NAME Mary Burkhardt		16. SOCIAL SECURITY NO. 578 05 4598			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		17. INFORMANT Rosemary Jaskiewicz		18. ADDRESS Upper Marlboro, Md 14301 Thorpe Lane			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (b) metabolic acidosis DUE TO, OR AS A CONSEQUENCE OF: (c) renal failure							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 87 January 3 1987 to January 8 1987			
22a. I certify that (I) (the hospital) attended the deceased from January 3 1987 to January 8 1987 , that (I) (we) lost saw the deceased alive on January 3 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.							
22b. SIGNATURE P. Basch MD		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Basch M.D.		22e. ADDRESS 8700 Central Ave., Landover, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12Jan1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland Maryland		25a. DATE RECEIVED BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death may be a traumatic event, the medical examiner may be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 0 2 8 5 4

1- STATE REGISTRAR		FOR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
Stephen		E.	Nosel
2a. DATE KNOWN OF DEATH	2b. HOUR	2c. DATE PRONOUNCED DEAD	
Jan 26 1987		Jan 26 1987 11:26 a.m.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)
Male	Caucasian	Aug. 15, 1917	69 RS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.	NEVER MARRIED	Prince George's
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Camp Springs	MALCOLM GROW USAF MEDICAL CENTER	Miner- Ret'd	Mining
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?
Maryland	Prince George's	Capital Heights	YES X NO
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
John	Mary	No	
16b SOCIAL SECURITY NO.	17 INFORMANT	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
169-07-4594	wife	PART I DEATH WAS CAUSED BY:	
	Florence M. Nosel	IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease	
	same as 13 a - e	DUE TO, OR AS A CONSEQUENCE OF	
		(b)	
		DUE TO, OR AS A CONSEQUENCE OF	
		(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Emphysema, mild			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?	
		YES NO X	
21a EXTERNAL CAUSE WAS	21b TIME OF INJURY	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
UNDERLYING CAUSE OF DEATH	HOUR A.M. MONTH DAY YEAR		
	P.M. 19		
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION	
WHILE AT WORK		STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an	Autopsy	Inspection	Inquiry
death resulted from:	Natural causes	Accident	Suicide
		Homicide	Undetermined manner
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
Augusto P. Rodriguez	Deputy	1/27/1987	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Augusto P. Rodriguez, M.D.	5009 Rayburn Ct., Temple Hills, MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (CITY OR TOWN COUNTY STATE)
Cremation	Jan. 28, 1987	Lee Crematory	Clinton, Prince George's, MD
24 FUNERAL DIRECTOR NAME	25a DATE RECD BY		25b REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	29 1987		John Barber
Old Alexander Ferry Rd., Clinton, MD 20735			

DIVISION OF VITAL RECORDS 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1877



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Chapman & Company

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02855

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE M. LAST O'DONNELL		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 TH 87		2b. HOUR 155 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10 1900	
7a. BIRTHPLACE (STATE OR FOREIGN) Ala.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Home		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE none 13b. COUNTY none 13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1701 Mass. Ave. NW 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Robert J. Fox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Neison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 577-34-3898		17. INFORMANT ADDRESS Mary E.O'Donnell (Daughter) same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIORENAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 HOURS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral Ischemia & Senile Dementia Complete Dislocated Right Hip Fracture					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 13 TH 19 87, to JANUARY 14 TH 19 87, that (I) (we) last saw the deceased alive on JANUARY 13 TH 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Marta Anne Schneider MD		DEGREE		22c. DATE SIGNED 1/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTA ANNE SCHNEIDER MD		22e. ADDRESS 5401 MACARTHUR BLVD. N.W. WASH. D.C. 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		24. FUNERAL DIRECTOR NAME ADDRESS Robert A. DeVol 2222 Wisc. Ave. DeVol Funeral Home Wash. DC.			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 22 1987 Julia Gordon-Radner			

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041919 JAN 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. PAGE 5, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02856

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
HELEN SCHWANER O'NEAL		1-20 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Female	White	NOV. 11, 1918	68 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
VIRGINIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Lanham		Doctors' Hospital of Pr Geo. Co.		BOOKKEEPER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		P.G.C.		GREENBELT	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FRANK SCHWANER		MARY DEMEL		4504 TUCKERMAN ST. RIVERDALE, Md. 20737	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		578-03-1611		CATHERINE SCHLEIG	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Circulatory and vascular disease				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		(c)	
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		Deputy		1-20-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct, Temple Hills, MD	
Augusto P. Rodriguez, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-24-1987		CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO.		RIVERDALE, Md. 20737		JAN 28 1987 Julia Gordon-Randall	

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041917 JAN 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02851

1- FOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT) Helen Sue Opstad		2b DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH 1-18 DAY 19 YEAR 87		2c HOUR M	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH Sept DAY 9 YEAR 1916	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD MONTH 1-18 DAY 19 YEAR 87	7d HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Up Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST John MIDDLE Pryor LAST Ladd		15. MOTHER'S MAIDEN NAME FIRST Myrtle MIDDLE Ladd LAST 5ST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 500 05 6401		17 INFORMANT ADDRESS Ole Andrew Opstad Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		M.D. _____		DATE SIGNED 1-19-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22Jan1987		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland Maryland		25a. DATE REC'D BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rudolph	

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042169 JAN 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02858
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen S. Orwick			2a. DATE OF DEATH MONTH DAY YEAR January 16, 1987		2b. HOUR 5:55A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 17, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W Shull		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Wise		13e. STREET ADDRESS / ZIP CODE 6537 Carlinda Ave. 21046	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 22 0139		17. INFORMANT ADDRESS M's Linda Reed 2737 Wood Lake Rd Michealville 20716	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident Left</u> DUE TO, OR AS A CONSEQUENCE OF <u>with Right Hemiplegia,</u> (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>Respiratory Arrest</u> (c) <u>Respiratory Arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15/87</u> to <u>1/16/87</u> , that (I) (we) lost saw the deceased alive on <u>1/15/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE ARVIND M. MEHTA MD		DEGREE MD		22c. DATE SIGNED 1/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIND M. MEHTA		22e. ADDRESS 7100 BALTIMORE AVE COLLEGE PARK, MD 20740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Van Horn Cemetery	
23d. LOCATION CITY OR TOWN Amanda Township		COUNTY Hancock		STATE Ohio	
24. FUNERAL DIRECTOR INC. NAME Harry H Witzke & Family Funeral Home		ADDRESS 4112 Old Columbia Pike Ellicott City		25. DATE REC'D. BY REGISTRAR JAN 27 1987	
26. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required number of deaths certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased's name, date of death, and place of death should be filled in on page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.)

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02859
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>LOUISE OWENS</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1 29 87</i>		2b. HOUR MIN. <i>6:45 P</i>	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR <i>10/17/11</i>	6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES CO MD.</i>		
10. CITY OR TOWN OF DEATH <i>CLINTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. MARYLAND Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Public Serv. Rep</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C&P Telephone</i>
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Apt. 616 8600 Mike Shapiro Dr. 20735</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Grigsby</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Stanley</i>		ADDRESS <i>5819 Marlboro Pike</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT Tarlton Rippy District Heights Md Apt 204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>Years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic Obstructive Lung Disease; D.T.D; Hypertension</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>1/25 87</i> to <i>1/29 87</i> , that (I) (we) last saw the deceased alive on <i>1/25 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/30/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Louis Kaufman</i>		22e. ADDRESS <i>8926 Woodyard Rd. Clinton MD 20735</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 02/01/87	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR <i>FEB 6 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
6633 Old Alexander Ferry Rd Clinton, Md 20735					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02801

1. DECEASED NAME (TYPE OR PRINT) ALFRED PARKER										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jan 26 1987		2b. HOUR OF DEATH 8:15 PM					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Jan 9 1925		6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Jan 26 1987		2d. HOUR 8 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Chesley				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Gen'l. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction				12b. KIND OF BUSINESS OR INDUSTRY None					
13a. STATE Prince Georges										13b. COUNTY Prince Georges		13c. CITY OR TOWN Conham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8821 Elmerden Pkwy	
14. FATHER'S NAME FIRST MIDDLE LAST William W. Parker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice E. Crutcher				17. INFORMANT Michael Parker - Brother				16b. SOCIAL SECURITY NO. 216-22-2385					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 216-22-2385				17. INFORMANT Michael Parker - Brother				16c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Dr. [Signature] M.D.				MEDICAL EXAMINER				DATE SIGNED Jan 26 1987					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-2-87		23c. NAME OF CEMETERY OR CREMATORY Chelham Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Chelham Maryland							
24. FUNERAL DIRECTOR NAME Samuel R. Woodfolk				ADDRESS 1722 North Capt				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE [Signature]					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(VR A15 ME (5))
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FEB 3 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carmela Patriarca					2a. DATE OF DEATH MONTH DAY YEAR 1 - 22 - 1987		2b. HOUR 7:40 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 - 22 - 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsburg		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3905 Matthews Dr. 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Angelo Yacurcio					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina Gianetta				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Henry A. Patriarca-son-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (to)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/18 19 86 to 1/22/87 19 87 , that (I) (we) lost saw the deceased alive on 1/22 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Beyram V. Maldonado MD					DEGREE MD			22c. DATE SIGNED 1/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beyram V. Maldonado					22e. ADDRESS 9440 Malsons Hill. Upper Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-26-1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

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040982 JAN 1987
STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02865
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward Harrison PEEK			2a. DATE OF DEATH January 12, 1987			2b. HOUR 4:17 AM				
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH 4 23 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Anadarko, Okla.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19-A Hillside Road 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Harrison Peek			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Unkown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Mary R. Peek		ADDRESS same as 13-e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Congestive Cardiac Failure and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>exacerbation of Chronic Obstructive Lung Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebrovascular Accident</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>January 11 1987</u> to <u>January 12 1987</u> , that (I) (we) lost saw the deceased alive on <u>January 11 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (see) the body after death										
22b. SIGNATURE <u>M Karim</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>01/12/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MOBARAK KARIM</u>			22e. ADDRESS <u>7610 Carroll Ave, Takoma Park, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 1/12/87		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN Laurel		P.G. Md.	
24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc.			ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707			25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <u>Julie Tindon-Randall</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02864
REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWARD A. PETERSON Sr.		2a. DATE OF DEATH MONTH DAY YEAR 1 29 87		2b. HOUR 12 ⁴⁰ P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Govt. 12b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving	
13a. STATE Laurel	13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Peterson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Werme		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO. 017-09-3526	17. INFORMANT ADDRESS Emma Peterson 3573 Fort Meade Rd. #608 Laurel, Md. 20707		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE ACUTE MYOCARD. INF. DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ALZHEIMER'S DISEASE				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/29 19 87 to 1/29 19 87 that (I) (we) last saw the deceased alive on 1/29 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) will view the body after death.				
22b. SIGNATURE R. MAGGIN	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MAGGIN	22e. ADDRESS 14353 LAUREL BOULEVARD LAUREL MD 20708			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 2, 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.	
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706		RECORDED BY REGISTRAR FEB 5 - 1987 REGISTRAR'S SIGNATURE Julia Rendon-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

143367-10324

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

042420 JAN 30 1987 87 02865

1. DECEASED NAME (TYPE OR PRINT) OTTO Bernard PFEIFFER			2a. DATE OF DEATH MONTH DAY YEAR 01 18 87		2b. HOUR 10:50A
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 25, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGGH		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Ret. Baker		12b. KIND OF BUSINESS OR INDUSTRY Private
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8600 Crain Highway 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Unk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Herman Pheiffer Same as 13 A-E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ORBITAL CELLULITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ORGANIC BRAIN DISEASE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEVERE PEDISSIDIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15/82</u> 19 <u>82</u> to <u>1/18/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/15/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>K. Sudhakar</i>		DEGREE		22c. DATE SIGNED 1/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SUDHAKAR MD		22e. ADDRESS 7656 NEW HAMPSHIRE AVE CAN GLEY PARK, MD 20783			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 01/21/87	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc			25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>
ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md 20735					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

212832

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02800

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ROSE		J. PIPER		Jan 3, 1987		3:40A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Cauc		01/28/1902		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ohio		USA				Prince George's MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel Beltsville Hospital		Typist		Councilor-Buchanan Mitchell Hayes	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Montgomery		Silver Spring		13e. STREET ADDRESS / ZIP CODE 20908	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Charles Berk		Mary Stoll		No		577-09-5342	
17. INFORMANT		ADDRESS		17a. DATE OF OPERATION		17b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Daughter		13208 Taney Drive					
Mary June High		Beltsville, Md. 20705					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetic ketoacidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				1/3/87	
LUIS A CASAS		14201 LAUREL PK DR. #221 LAUREL MD 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Jan. 6, 1987		Parklawn Cemetery		Rockville Montgomery Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis J. Collins, Jr.		JAN 6 1987					
500 University Blvd., W. Silver Spring, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

Continued from page 10

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WINTER 2011

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JUNE 2007

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042077 JAN 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 0 2 8 6 /
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna E. Pokorny			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1987		2b. HOUR 11:00PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kocsis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 082-18-9360		17. INFORMANT ADDRESS Harry Pokorny same as #13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Left Hemispheric Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Micro-embolism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atrial Fibrillation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from January 11, 1987 to January 21, 1987 , that (I) (we) lost saw the deceased alive on January 21, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE PHYSICIAN		22c. DATE SIGNED 1-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joselito D. Magday, MD		22e. ADDRESS 11701 Roby Ave., Beltsville, Md. 20705			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Kew Gardens Queens New York		24. FUNERAL DIRECTOR NAME Donald V. Borgwardt			
24a. ADDRESS 4400 Powder Mill Rd. Beltsville, Md. 20705		25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

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042500 FEB-28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02808

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles W. Price			2a. DATE OF DEATH MONTH DAY YEAR 1/24/87		2b. HOUR 455 A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1/13/12		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Eng.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. NRL
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George		
13c. CITY OR TOWN Camp Springs			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Z. Price			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina M. Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 114-10-0024		17. INFORMANT ADDRESS George E. Price 14901 W. Auburn Rd. Accokeek, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse histiocytic lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 7 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 1-23 1986 to 24 January 1987 , that (I) (we) saw the deceased alive on 1-23 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Kai-Yin Yeung, M.D.		DEGREE M.D.		22c. DATE SIGNED 1-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin YEUNG, M.D.		22e. ADDRESS 8926 Woodyard Rd #201 Clinton, MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/87		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		23e. DATE REC'D. BY REGISTRAR JAN 30 1987			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall	

BP _____

BOX COTTON #1-528

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042291 JAN 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02869
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Heiskell Henry Price				January 19, 1987		7:10p _M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	Caucasian	MONTH DAY YEAR 11 14 03		83		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Tennessee	U.S.A.			Prince George's MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale	Leland Memorial		Supervisor		Communications		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
Maryland		P.G.	Hyattsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3701 Kennedy Place, 20782 Union		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST William Edward Price		FIRST MIDDLE LAST Margaret Lucinda Brooks		17. INFORMANT (Daughter) ADDRESS Mrs. Mildred Ferrell, Same as Line 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
		Cardiac arrest		Acute Myocardial Infarction		Coronary Atherosclerosis	
						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						1 hr.	
						2 days.	
						5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
Renal Failure; Anemia.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/18, 1987, to 1/19, 1987, that (I) (we) lost saw the deceased alive on 1/19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Jack C. Meshel		M.D.				1/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Jack C. Meshel		5806 Baltimore Ave Hyattsville Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1-23-1987		Hawkins Cty. Mem. Gdns Rogersville, Tenn.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home		4739 Baltimore Ave., Hyattsville, Md. 20781		JAN 28 1987		Julia Davidson-Randall	



041345 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02870

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		Hilda Mildred Prickett					Jan 13 1987					11:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. UNDER 1 YR.	8. UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Female	White	Feb. 4, 1898	88			Jan 13 1987					11:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Ohio	U.S.A.				Prince George's County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Maryland		4903 Cherokee Street				Chemical Analyst		Bureau of				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE		
Maryland		P.G.		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4903 Cherokee Street		20740		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		17b. DURNBAUGH DRIVE		
George		Ella		No		578-32-7033		Robert L. Prickett		Dayton, Ohio 45432		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
None												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED				
John S. Rogers		M.D.		Dep.				Jan 13, 1987				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Road Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		01/14/87		Maryland National Mem. Park		Laurel		P.G.		Maryland		
23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		JAN 19 1987								
4739 Baltimore Avenue Hyattsville, Md. 20781		Julia Henderson										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-2, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

134710

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒ , item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) George Herman Purschwitz					2a. DATE OF DEATH MONTH DAY YEAR 01 21 87 2b. HOUR 01:35am					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 15 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEM. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Transit Co.		
13a. STATE MARYLAND					13b. COUNTY P.G.		13c. CITY OR TOWN BRENTWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Purschwitz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rau					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-9717		17. INFORMANT ADDRESS Mrs. Ruziski Purschwitz, Same as Line #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ischemic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/13/87 to 1/20/87, that (I) (we) last saw the deceased alive on 1/20/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <i>Abraham DABELA</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-22-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abraham DABELA				22e. ADDRESS 2404 Queensbury Rd Riverdale MD 20737						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-23-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland				
24. FRANKLIN CASCH'S SONS FUNERAL HOME, P.A. NAME ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>				

2552

4

043285 FEB 1987

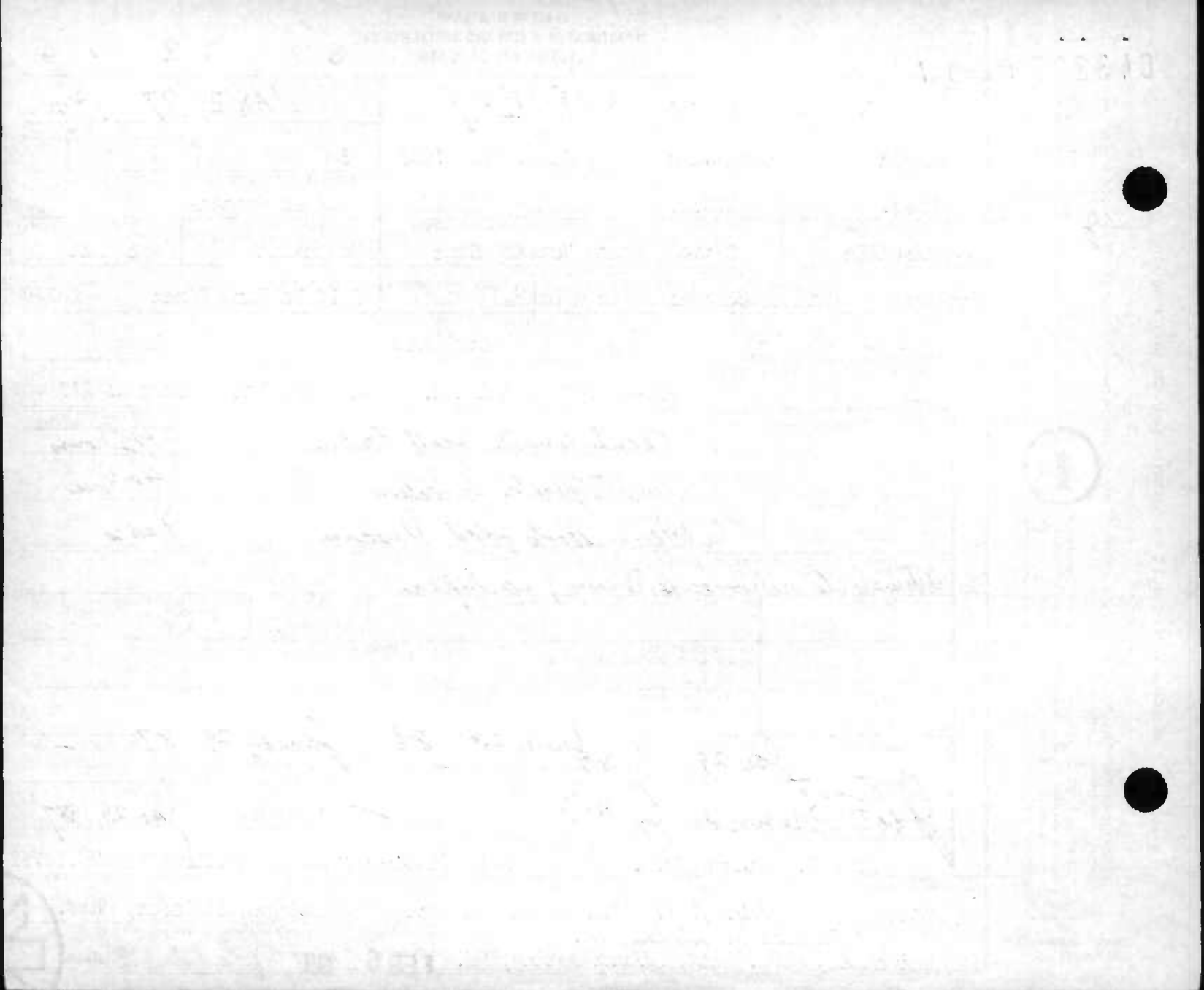
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8702872
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Helen Raftery		2a. DATE OF DEATH MONTH DAY YEAR JAN 29 87		2b. HOUR 10 ⁰⁰ P. M.	
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15 1903	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 83 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3612 De Pauw Place		ZIP CODE 20740	
14. FATHER'S NAME FIRST MIDDLE LAST Timothy J. Deasy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Long			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 029-42-7496		17. INFORMANT ADDRESS Elaine R. Walter daughter same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours 48 hours Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Cardiovascular Disease; Cerebrovascular Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 28 1986</u> to <u>January 29 1987</u> , that (I) did last saw the deceased alive on <u>Jan 29 1987</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I was did) not view the body after death.					
22b. SIGNATURE <u>John F. Brennan Jr. MD</u>		DEGREE		22c. DATE SIGNED <u>Jan 29, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Brennan, M.D.		22e. ADDRESS 3415 Hamilton Street, Hyattsville, Md. 20782			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Middlesex, Mass.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 6 1987			
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



041143 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02873
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Williams RECK			2a. DATE OF DEATH MONTH DAY YEAR January 14, 1987		2b. HOUR 7:33 P M
3. SEX Female	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR 3-25-1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manufacture		12b. KIND OF BUSINESS OR INDUSTRY HATS
13a. STATE Maryland		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Williams		15. MOTHER'S MAIDEN NAME Phoebe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 166-09-2067		17. INFORMANT Robert O. Reck (SAME AS ABOVE #13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS. 15 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Anemia, rheumatoid arthritis, diabetes mellitus.</u>					
19a. DATE OF OPERATION 1/13/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED thrombosis femoral graft		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/14 to 1/14 1987, that (I) (we) lost saw the deceased alive on 1/14 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert A. Depetris MD		DEGREE MD		22c. DATE SIGNED 1/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Depetris MD		22e. ADDRESS 14300 GALLANT FOX LA #R2 Bowie Md 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-1987		23c. NAME OF CEMETERY OR CREMATORY Sunset Man. PK.	
23d. LOCATION CITY OR TOWN Buck Co, PA.		23e. COUNTY Buck Co, PA.			
24. FUNERAL DIRECTOR NAME Barranco F.H. Severna Park, MD		25a. DATE REC'D BY REGISTRAR JAN 19 1987			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked for item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

From [illegible] to [illegible]
[illegible] 11-1-77

Re: [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

042417

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02814

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. DATE PRONOUNCED DEAD		
STEPHEN E. REED			JAN 15 1988			JAN 15 1988			JAN 15 1988			JAN 15 1988		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS.									
M	W	FEB 14 37 49	49 YRS	MONTHS	DAYS	HOURS	MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
PRAIRIE GROVE ARK.			U.S.A.			NEVER MARRIED			PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY					
LAUREL			BREXTER LAUREL BELT RIVER			ARO Space Eng.			CTA					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD			PRINCE GEORGE'S			WACO DR.			YES			20772		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
NORMAN ELLIOTT REED			MARY PAULINE NIXON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
YES			1955-1959			SANDRA SUE REED			SAME AS 13 A-E					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			
(b) CORONARY THROMBOSIS			
DUE TO, OR AS A CONSEQUENCE OF			
(c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
AT WORK AT WORK					

22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion	
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
								Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
John S. Rogers		M.D. Dep.		JAN 15 1988					
EXAMINER'S NAME		ADDRESS							
John S. Rogers		1919 Seminary Rd. Sil. Spg. Md							

23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		01/20/87		Maryland Veterans Cem.		Cheltenham Prince George's Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home, Inc.		JAN 29 1987		Julia Davidson-Rodner			
NAME		ADDRESS					
6633 Old Alexander Ferry Rd Clinton, Md 20735							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5)) 6633

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Wayne

Hugh

Riddle

2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
1/14 19 87
2b. HOUR
M
7:30
P. M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

May 8, 1923

6. AGE (IN YEARS)

63 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

1/14 19 87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County MD.

10. CITY OR TOWN OF DEATH

College Park

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

9014 Rhode Island Avenue, #710

17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Unemployed

17b. KIND OF BUSINESS OR INDUSTRY

Unemployed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince George's College Park

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS

9014 Rhode Island Avenue, #710

14. FATHER'S NAME

FIRST

Hugh

MIDDLE

D.

LAST

Riddle

15. MOTHER'S MAIDEN NAME

FIRST

Geneva

MIDDLE

LAST

Wolfe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

233-42-8811

17. INFORMANT (Brother)

David W. Riddle Clarksville, Md. 21029

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease.

DUPLICATE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUPLICATE OF

DUPLICATE OF

(c) DUPLICATE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

None

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED 1/15/87

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

01/17/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Union Cemetery

23d. LOCATION CITY OR TOWN

Morgantown

COUNTY

West Virginia

24. FUNERAL HOME (NAME AND ADDRESS)

Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JAN 28 1987

1888-1889



1888-1889

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **02810**

1. DECEASED NAME (TYPE OR PRINT) Robert Chester Riley, Sr.				2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 1-9 1987				2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 19 YEAR 34	6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	7c. DATE PRONOUNCED DEAD MONTH 1 DAY 9 YEAR 1987		7d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9734 52nd Ave 20740	
14. FATHER'S NAME FIRST Dock MIDDLE LAST Riley				15. MOTHER'S MAIDEN NAME FIRST Katie MIDDLE LAST Jordan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-30-0045		17. INFORMANT ADDRESS Viola Riley same as above			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 6:30 A.M. MONTH 1 DAY 8 YEAR 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 9734 52nd Avenue CITY OR TOWN College Park COUNTY P. G. STATE Md.	

22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD	
DATE SIGNED 1-9-87		MEDICAL EXAMINER	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Jan 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION CITY OR TOWN Laurel COUNTY P.G. STATE Maryland	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A. ADDRESS Laurel, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AT A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201



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043107 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02871
1- FOR STATE REGISTRAR												
1. DECEASED NAME FIRST MIDDLE LAST 587 Doris Blendell Robinson						2a. DATE KNOWN OF DEATH MONTH DAY YEAR Jan 26, 87			2b. HOUR OF ESTIMATED DEATH P.M.			
3. SEX F	4. RACE BLK	5. DATE OF BIRTH MONTH DAY YEAR May 3, 28, 58		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 28	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan 22, 1987		2d. HOUR 3:30 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Adelphi			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1836 McTzgerott Rd Apt. 1526				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY U.S. Customs			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md		13b. COUNTY Prince Georges		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1836 McTzgerott Rd Apt. 1526		20783		
14. FATHER'S NAME FIRST MIDDLE LAST Alonzo Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Robertson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 221-16-0311		17. INFORMANT ADDRESS Wilmington, Del. Mildred Holmes, 2013 N. Franklin St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Div.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>												
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Joel Rogers</u>						TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE SIGNED Jan 27, 1987		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/30/87		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware				
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, 7400 Georgia Ave. N.W.				ADDRESS Washington, DC		25. DATE RECEIVED BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE				

McGuire Funeral Service, 7400 Georgia Ave. N.W.,

Washington, D.C.

Rollins Green Park

West Chester, Pennsylvania

Funeral

1/17/87

No

Alonso Robinson

227-18-0311

Married Holmes, 2018 W. Franklin St.

Wilmington, Del.

Married Robertson

Attorney

W. Customs

North Carolina United States

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02878
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LLEWELLEN LLENORA ROCHE LLEWELLEN ROCHE		2a. DATE OF DEATH MONTH DAY YEAR 1-30-87		2b. HOUR MIN. 8:25 P	
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 7-24-1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic		13a. STREET ADDRESS / ZIP CODE Box 201 Mattawoman-Beantown Rd. 20601	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander I. Clements		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Neal		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 577-34-7709		17. INFORMANT ADDRESS James E. Roche Jr., Same As 13abcde			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Renal failure.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-24-1987 to 1-30-1987 , that (I) (we) last saw the deceased alive on 1-30-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE h snelt		DEGREE M.D.		22c. DATE SIGNED 1-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BATH, GIRIJA SHANKAR		22e. ADDRESS Charles Prof. Center #207 Waldorf, Maryland 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-3-87		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.		25a. DATE REC'D. BY REGISTRAR FEB 3 1987			
24. FUNERAL DIRECTOR NAME ADDRESS The Hunt Funeral Home, Waldorf, Md.		25b. REGISTRAR'S SIGNATURE John E. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified to make a post-mortem examination.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 02879

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen MIDDLE: V. LAST: Roland			2a. DATE OF DEATH MONTH: January DAY: 27 YEAR: 1987		2b. HOUR 10:00 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH: April DAY: 19 YEAR: 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10800 Potomac Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary - Ret.		12b. KIND OF BUSINESS OR INDUSTRY Teamsters 246	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland 13b. COUNTY: Prince George 13c. CITY OR TOWN: Glenn Dale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10800 Potomac Street 20769		
14. FATHER'S NAME FIRST: Austin MIDDLE: I. LAST: Jarboe			15. MOTHER'S MAIDEN NAME FIRST: Martha MIDDLE: E. LAST: Garner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-10-2556		17. INFORMANT Susan Abels			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Severe Chronic Lung Disease</u> (b) <u>Severe Chronic Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Severe Chronic Lung Disease</u> (c) <u>Severe Chronic Lung Disease</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> 19 <u>87</u> to <u>1/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George P. Kalas</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George P. Kalas</u>		22e. ADDRESS 6160 Oxon Hill Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/87		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN: Washington, D.C. COUNTY: STATE:	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		24b. ADDRESS 6160 Oxon Hill Rd.		25a. DATE REC'D. BY REGISTRAR FEB 2 1987		25b. REGISTRAR'S SIGNATURE <u>Julia London</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

15-00000-1

January 27, 1947
Washington, D.C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.
Very truly yours,
[Signature]
[Title]
[Address]

1-1-47
[Faint text and markings at the bottom of the page, including a date stamp and illegible markings.]

042698 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the office of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

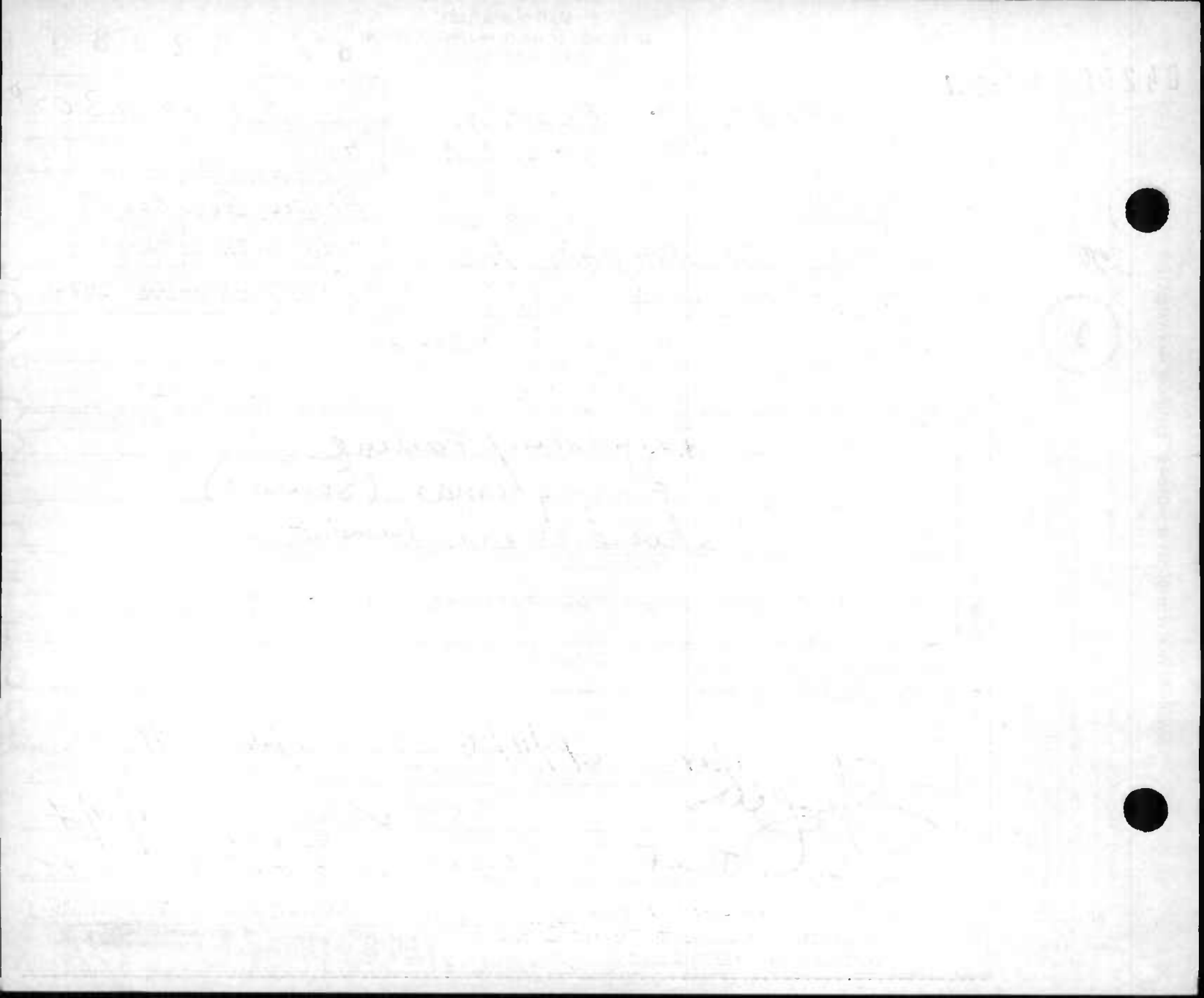
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8702880

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
FIRST MIDDLE LAST		1-26-87		3-05 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH	
				MONTH DAY YEAR	
				Nov 17 1907	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Washington DC		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Clinton		So. Maryland Hosp.		Prinle Georges Co MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Corp Officer		Banking			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Pr George		Suitland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Eugene Rosafy		Elizabeth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		579 14 5564		Nancy C Foutz Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema (Severe)</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe chronic bronchitis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/86</u> , 19 <u>87</u> , to <u>1/26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>[Signature]</u>				<u>1/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
S. JOSEF		4467 OLD BARNETT AVE		20748	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		30 Jan 1987		Arlington Nat'l	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE REC'D. BY REGISTRAR	
Robert E Wilhelm Funeral Home		Suitland Maryland		FEB 2 1987	
26. REGISTRAR'S SIGNATURE		26b. ADDRESS			
<u>[Signature]</u>					



042269 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. If item 21 is marked or item 18 shows any injury, or other traumatic event, and a coronial case must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and a coronial case must be notified at once.

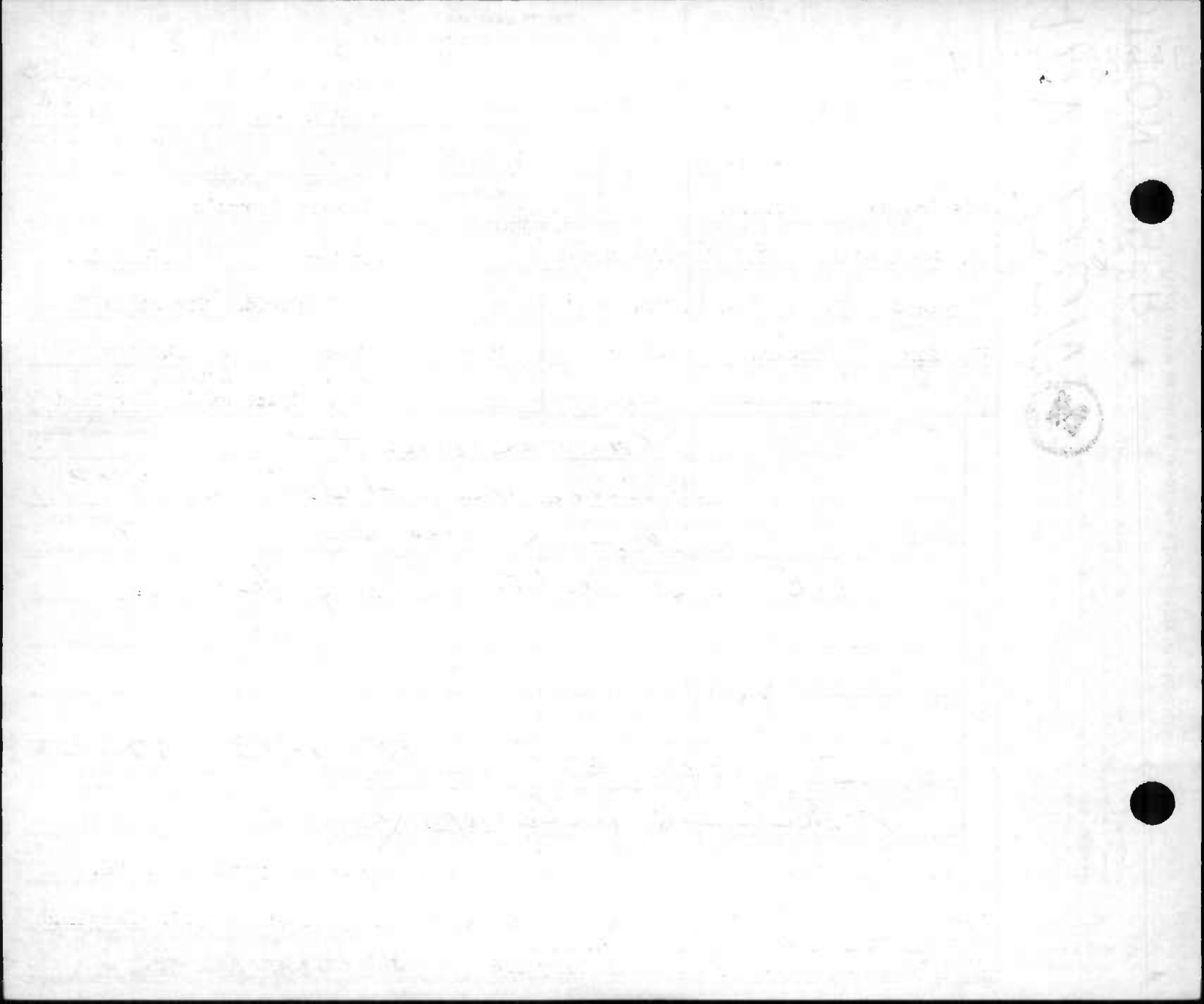
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02881

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY LAURA KIDDER ROSS				2a. DATE OF DEATH MONTH DAY YEAR January 18, 1987		2b. HOUR A M 9:00 A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH W. Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2008 Sheridan Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN W. Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2008 Sheridan Street 20782		14. FATHER'S NAME FIRST MIDDLE LAST William Richard Kidder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Laura Shirley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 428-14-8647		17. INFORMANT Burr D. Ross, Jr., Hyattsville, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Intense heat & stress</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>admission to hospital long term</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALLOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE STREET	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION CITY OR TOWN COUNTY STATE STREET		21h. LOCATION CITY OR TOWN COUNTY STATE STREET	
22. I certify that (I) (this hospital) attended the deceased from <i>1-10-87</i> to <i>1-18-87</i> that (I) (we) last saw the deceased alive on <i>1-10-87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
27b. SIGNATURE <i>J. Richard Lilly</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 1-19-87	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Richard Lilly				27e. ADDRESS 5804 Baltimore Ave., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-21-87		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, P.G., Maryland	
24. FUNERAL DIRECTOR FRANK'S GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <i>Julia...</i>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02882

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				
Henry F. Routhier					1	30	87	7:09 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male	Caucasian	10/27/20		66		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Rhode Island	U.S.A.			Prince Georges MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale	Leland Memorial Hospital		Delivery Man		Plaza			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
Maryland		Pr. Geo's.	College Park	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9715 Narragansett Pkwy. 20740			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		17. INFORMANT ADDRESS				
unknown		Eva LaMarr		Jeanette R. Routhier Same as #13				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		032-05-5458		Jeanette R. Routhier Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac Dysrhythmia</u>							minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Constrictive heart failure</u>							5 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic Cardiovascular Disease</u>							Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure, Diabetes Mellitus</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
N/A				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR		N/A				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 19 <u>87</u> , to <u>1/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
<u>Paul A. DeVore, M.D.</u>						1/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
PAUL A. DEVORE, M.D.				4203 Queenbury Road Hyattsville Md 20781				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		2/2/87		Washington Nat'l. Cem.		Suitland, Prince George's, Md.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				FEB 6 1987		Julia Swinson-Rudner		

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RECEIVED

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042986

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02883

1- REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																																																																							
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE PRONOUNCED DEAD										2d. HOUR																																																																																																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.																																																																																									
7a. BIRTHPLACE (STATE OR)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK)										12b. KIND OF BUSINESS																																																																					
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS										14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										18. CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21d. PLACE OF INJURY										21e. LOCATION										22a. I certify that I took charge of the remains described above, held an										22b. DATE										22c. NAME OF CEMETERY OR CREMATORY										22d. LOCATION										22e. DATE REC'D. BY REGISTRAR										22f. REGISTRAR'S SIGNATURE									
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										23e. DATE REC'D. BY REGISTRAR										23f. REGISTRAR'S SIGNATURE																																																																																									
24a. BURIAL, CREMATION, REMOVAL										24b. DATE										24c. NAME OF CEMETERY OR CREMATORY										24d. LOCATION										24e. DATE REC'D. BY REGISTRAR										24f. REGISTRAR'S SIGNATURE																																																																																									

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

DONOR

STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.

JAN 29 1987

JAN 29 1987

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040190 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02884

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH			2e. HOUR		
Richard Roy			1/3 1987			1/3 1987			1/3 1987			7:30 A.					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Male	Black	Mar. 13, 1927	59 YRS.			Oklahoma			USA			WIDOWED			XX Prince George's County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY								
Capitol Heights			5316 Altoona Street			Retired											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Prince George's			Capitol Heights			YES			5316 Altoona Street			20743		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Bert Roy			Martha Dansby			yes			445 22 1366			Brenda Gleaton-friend-5316 Altoona			Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROPRIATE BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Metastatic carcinoma																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) carcinoma of the stomach.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
None																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
None						YES			NO								
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED											
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			P.M. 19			None											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION											
WHILE AT WORK			STREET, FACTORY, FARM, ETC.)			STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED											
EXAMINER'S NAME			M.D.			MEDICAL EXAMINER											
John S. Rogers, M.D.			Deputy			1919 Seminary Road											
(TYPE OR PRINT)			ADDRESS			Silver Spring, Montgomery County, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			COUNTY			STATE		
Burial			Jan. 18, 1987			Arlington National Cemetery			Arlington, Va								
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Stewart Funeral Home			JAN 7 1987														

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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12-10-10



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Innes RUSSELL			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1987		2b. HOUR 5:05 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 10, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT	12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING	
13a. STATE Md.	13b. COUNTY P.G.C.	13c. CITY OR TOWN GREENBELT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7036 HANOVER PKWY. 20770	
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER McKILLOP		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH STEWART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-42-5050		17. INFORMANT ADDRESS VINCENT RUSSELL 97 A. WHITE ST., EATONTOWN N.J. 07724	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypertension DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Kidney Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 147 56 58	
22a. I certify that (1) this hospital attended the deceased from 1/4/87 to 1/4/87 , and that in my opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)					
22b. SIGNATURE Lewis H. Dennis		DEGREE		22c. DATE SIGNED 1/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 831 Univ. Blvd. E, Silver Spring, Md. 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-8-1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING, MONTG. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25. DATE REC'D. BY REGISTRAR JAN 14 1987	
				25. REGISTRAR'S SIGNATURE Julia Henderson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and page 4 from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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040703 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LOUISE LAST RYAN						2a. DATE OF DEATH MONTH DAY YEAR Jan. 3, 1987		2b. HOUR 3:30 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MARCH 2 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6111 Roanoke Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6111 Roanoke Ave. 20737	
14. FATHER'S NAME FIRST MARIUS MIDDLE SIMEON LAST				15. MOTHER'S MAIDEN NAME FIRST CATHERINE MIDDLE DOHERTY LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-20-1942		17. INFORMANT ADDRESS Catherine Ryan, Same as Line #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis, General APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Nephrosclerosis; Azotemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Mar 5 1986, to Jan 3 1987, that (I) (we) saw the deceased alive on Jan 2 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John F. Brennan, Jr. MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan 3, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Brennan, Jr.				22e. ADDRESS 3415 Hamilton St., Hyattsville, Md. 20782					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-07-87		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR'S NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE John F. Brennan, Jr.	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "other", the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 02881			
1. DECEASED NAME (TYPE OR PRINT) RICHARD JOSEPH SAINT										2a. DATE OF DEATH MONTH DAY YEAR JAN 27 1987		2b. HOUR 1:15PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.							
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Radioman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Waldorf				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2526 Lisa Dr. / 20601							
14. FATHER'S NAME FIRST Richard MIDDLE Saine LAST Orpha				15. MOTHER'S MAIDEN NAME FIRST Orpha MIDDLE Heck LAST Heck									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 1937-1963		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes		17. INFORMANT Florence J. Saint - Same as #13-									
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO, OR AS A RESULT OF, (b) ACUTE GASTROINTESTINAL BLEEDING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) ALCOHOLIC CIRRHOSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aspiration Pneumonia, Sepsis, Alcoholic Coagulopathy													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (this hospital) attended the deceased from 1 January 19 87 , to 27 January 19 87 , that (1) the last saw the deceased alive on 27 January 19 87 , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (1) the (did) not view the body after death.													
22a. SIGNATURE Dr. B. Morris MD						22b. ADDRESS 20331-5300		22c. DATE SIGNED 27 Jan 87					
22d. PHYSICIAN'S NAME PETER H. MAPES, CAPT, USAF, MC 215-52-5076 AFSC 9321 Malcolm Grow USAF Medical Center						22e. ADDRESS MALCOLM GROW MEDICAL CENTER ANDREWS AFB MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-31-87		23c. NAME OF CEMETERY OR CREMATORY Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Pr. Geo., Md.							
24. FUNERAL DIRECTOR NAME Huntt Funeral Home				ADDRESS P. O. Box 156 Waldorf, Md 20601		25a. DATE REC'D. BY REGISTRAR JAN 30 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

1. The first step in the process of determining the value of a property is to identify the property and its location. This is done by obtaining a description of the property from the owner or a reliable source. The description should include the name of the property, its address, and any other identifying information. Once the property has been identified, the next step is to determine its value. This is done by comparing the property to similar properties that have been sold recently. The value of the property is then determined based on the results of this comparison.

2. The second step in the process of determining the value of a property is to identify the property and its location. This is done by obtaining a description of the property from the owner or a reliable source. The description should include the name of the property, its address, and any other identifying information. Once the property has been identified, the next step is to determine its value. This is done by comparing the property to similar properties that have been sold recently. The value of the property is then determined based on the results of this comparison.

3. The third step in the process of determining the value of a property is to identify the property and its location. This is done by obtaining a description of the property from the owner or a reliable source. The description should include the name of the property, its address, and any other identifying information. Once the property has been identified, the next step is to determine its value. This is done by comparing the property to similar properties that have been sold recently. The value of the property is then determined based on the results of this comparison.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use on the burial-transit permit. Then please forward to the Department of Health and Mental Hygiene, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02688

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Sadeqh Ebtehaj Samii			2a. DATE OF DEATH MONTH DAY YEAR 1 9 87		2b. HOUR 1328 M
3. SEX Male	4. RACE Iranian	5. DATE OF BIRTH MONTH DAY YEAR Feb 1 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iran	7b. CITIZEN OF WHAT COUNTRY? Iran	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seventh Day Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iranian Government		12b. KIND OF BUSINESS OR INDUSTRY Retired
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4601 N. Park Ave. #920	
14. FATHER'S NAME FIRST MIDDLE LAST Issa None Samii		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Omi None Samii			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Fatola Samii (Cousin) Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder DUE TO, OR AS A CONSEQUENCE OF (b) and Resp. Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 1-9-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 12-29 1986		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 12-29 1986 to 1-9-87 19____, that (I) (we) last saw the deceased alive on 1-9-87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two) (and) (did not) (saw the body after death)					
22b. SIGNATURE M. ALI. NAJFICY		DEGREE MD		22c. DATE SIGNED MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ALI. NAJFICY		22e. ADDRESS 3921 - FERRARA DR. S.S.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/87		23c. NAME OF CEMETERY OR CREMATORY Islamic Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Arlington Va.		24. FUNERAL DIRECTOR NAME ADDRESS DeVol Funeral Home, Inc. 2222 Wiscon. Ave. N.W. Wash. DC			
25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE Alia Tardem-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

04068

JAN 14 1987

999999
DHAM 1/13/87
(VRA 15.4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST			
Anne		Mary		SANTORO		January 10, 1987		7:55P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		October 23, 1922		64		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Prince George's County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		AMI Doctors' Hospital		Housewife		N/A			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Delaware		Sussex		Ocean View				P. O. Box 300 19970 99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Louis		DeGeorge		Innocenza		Cataldi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		577-20-7679		John D. Santoro		P. O. Box 300 Ocean View, Delaware			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Metastases</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Ovaries &</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Neutropeny</i> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 yr</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 86 to Jan. 10 1987, that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<i>Benjamin S. Pecson</i>				1-11-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Benjamin S. Pecson		6106 Old Silver Hill Rd. Forestville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/13/87		Resurrection Cemetery		Clinton P.G. Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George P. Kalas Funeral Home Oxon Hill, Md.		JAN 13 1987		<i>Julia Benson</i>					

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Mildred Edith Sasscer				1/17/87				12:02 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White	June 12, 1903		83 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U. S. A.				Prince Georges MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY				
Clinton	Southern Maryland Hospital		Homemaker		Own Home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Pr. Geo's		Upper Marlboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE					
William Herbert Lusby		Edith Young		7805 Sasscer Lane/20772					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		---		7805 Sasscer Lane, Upper Marlboro, Md. 20772					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>SEPTICEMIC SHOCK</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>SEPTICEMIA</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CEREBROVASCULAR ACCIDENT</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/17/87 to 1/17/87, that (I) (we) lost saw the deceased alive on 1/17/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
G. S. Nachnani				M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
G. S. Nachnani, M.D.				8926 Woodyard Road Clinton, Maryland 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		1/20/87		Cedarville Assemblies of God Cemetery		Brandywine (Pr. Geo's) Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Richard A. Coleman Funeral Home.				Upper Marlboro, Maryland 20772		30 1987		Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death was a violent event, the medical examiner must be notified at once.

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Released by Dr. Rodriguez
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove card at bottom. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 02891

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earsell Savage		2a. DATE OF DEATH MONTH DAY YEAR 1/11/87		2b. HOUR 6:45 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR November 11, 1916	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 10 YEARS HOURS MIN. 70 YRS.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hosp. Ctr.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Largo		13c. CITY OR TOWN Largo	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Tucker		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 183-20-6219		17. INFORMANT ADDRESS Ann Pratt 1703 Redbud Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) complication of the lung					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/10/87 , 19 87 , to 1/11/87 , 19 87 , that (I) (we) last saw the deceased alive on 1/11/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Carl Almond DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL ALMOND MD				22e. ADDRESS 7900 Old Branch Clinton MD 20735	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-14-87		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cem.	
24. FUNERAL DIRECTOR NAME Maile Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Newport News, Va		25a. DATE REC'D. BY REGISTRAR 20 1987	
				25b. REGISTRAR'S SIGNATURE John S. ...	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES L. SAVOY					2a. DATE OF DEATH MONTH DAY YEAR 01 04 87 2b. HOUR 8:38p M														
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct 8 1953		6. AGE (IN YEARS LAST BIRTHDAY) 33		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.											
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.													
12. CITY OR TOWN OF DEATH CLINTON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY											
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Charles		16c. CITY OR TOWN Waldorf		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 4902 B Savoy Place 20601											
17. FATHER'S NAME FIRST MIDDLE LAST James Kelso Savoy					18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Adams														
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]					19b. SOCIAL SECURITY NO. 212 62 0451					19c. INFORMANT ADDRESS Sheila Savoy SAA									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemoptysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Respiratory Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Emergency @ Pneumothorax</u>																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Emergency.</u>					19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21c. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1-3-87</u> , to <u>1-4-87</u> , that (I) (we) last saw the deceased alive on <u>1-4-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>M.A. NAFICY</u>										22c. DATE SIGNED MD									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.A. NAFICY										22e. ADDRESS 3921 - FERRARO DR. S.S.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 9 Jan 1987					23c. NAME OF CEMETERY OR CREMATORY St Peter's Cath Ch									
23d. LOCATION CITY OR TOWN Waldorf					23e. COUNTY Charles					23f. STATE Md									
24. FUNERAL DIRECTOR NAME Martell Adams, Aquasco Md										25. DATE RECEIVED BY REGISTRAR JAN 14 1987					26. REGISTRAR'S SIGNATURE Julia Sanders-Randall				

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 02893

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHELBY Jean SCHEIBACH			2a. DATE OF DEATH MONTH DAY YEAR 01-31-87		2b. HOUR 12 44PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1939		
6. AGE (IN YEARS LAST BIRTHDAY) 47		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		
12b. KIND OF BUSINESS OR INDUSTRY Restaurant		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clyde R. Flagle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mary Walker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 220-11-9107		17. INFORMANT (Husband) 5305 Hamilton Street #1 John F. Scheibach Hyattsville, Md. 20781				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diarrhoeal coma</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from 1/31/87 to 1/31/87, that (1) (we) last saw the deceased alive on 1/31/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Dr. H. A. D. M. K.		22c. ADDRESS Chilton Md		22d. DATE SIGNED 2/2/87		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/05/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland		24. FUNERAL DIRECTOR'S NAME Francis Gasch's Sons Funeral Home, p.a. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR FEB 6 1987		
25b. REGISTRAR'S SIGNATURE John F. Scheibach						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 02894

1- FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) Joan Parks Screven			3. DATE OF BIRTH MONTH DAY YEAR March 16, 1949		4. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		5. DATE OF DEATH MONTH DAY YEAR January 30, 1987		6. HOUR 9:45A M		
7a. SEX Female		7b. RACE Black		8. DATE OF BIRTH MONTH DAY YEAR March 16, 1949		9. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		10. DATE OF DEATH MONTH DAY YEAR January 30, 1987		11. HOUR 9:45A M	
12a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			12b. CITIZEN OF WHAT COUNTRY? U.S.A.			13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			14. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
15. CITY OR TOWN OF DEATH Clinton			16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7006 K Killarney Street			17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Day Care Provider			18. KIND OF BUSINESS OR INDUSTRY Self Employed		
19. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 19a. STATE Md.			19b. COUNTY P.G.			19c. CITY OR TOWN Clinton			19d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20. FATHER'S NAME FIRST MIDDLE LAST Lucus Parks			21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris White			22. STREET ADDRESS / ZIP CODE 7006 Killarney Street			23. ZIP CODE 20735		
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			25. SOCIAL SECURITY NO. 1977-1980			26. INFORMANT Earl B. Screven (Husband)			27. ADDRESS Same as #13		
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
29a. DATE OF OPERATION			29b. CONDITION FOR WHICH OPERATION WAS PERFORMED			30a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			30b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
31a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
32a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32c. LOCATION STREET CITY OR TOWN COUNTY STATE					
33. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>86</u> to <u>1/30/</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>1/30/</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
34. SIGNATURE <u>[Signature]</u> MD						35. DEGREE MD			36. DATE SIGNED 1/30/87		
37. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Berwa						38. ADDRESS 1300 Mercantile Lane #134 Landover Md.					
39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			40. DATE 2/2/87			41. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery			42. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland		
43. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. 6633 Old Alexander Ferry Road Clinton, Maryland						44. DATE RECEIVED BY REGISTRAR FEB 6 1987			45. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked off, item 28 shows any injury, or other traumatic cause, the certificate must be notated at once.

ATLAS NO. 100 1000



042628 FEB 28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death investigation should be notified at once.

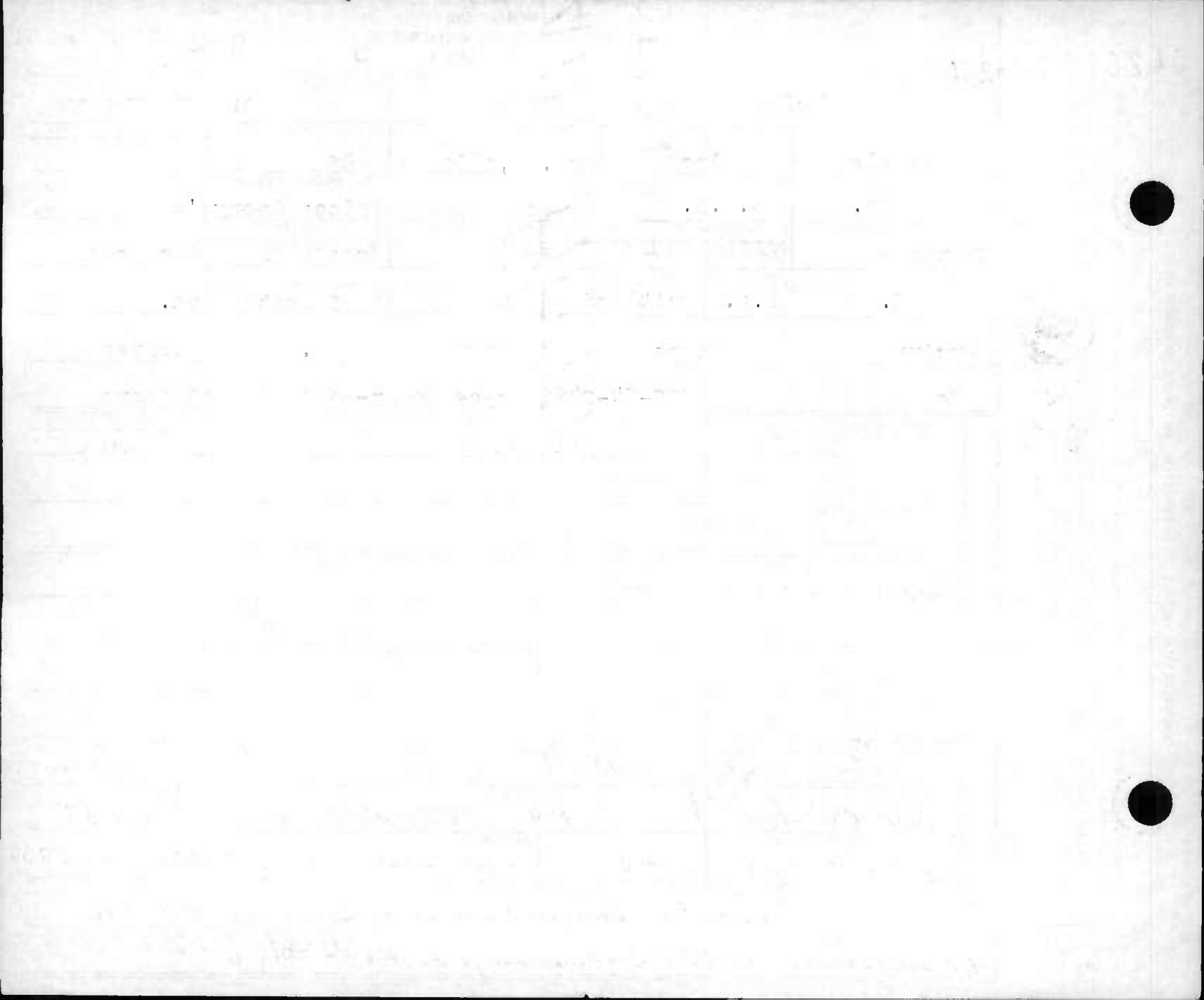
BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARSEDA SELDON			2a. DATE OF DEATH MONTH DAY YEAR 01 06 87			2b. HOUR 6 25A M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NURSING CARE CENTER PGGH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.				13b. COUNTY P.G.		13c. CITY OR TOWN Suitland	
14. FATHER'S NAME FIRST MIDDLE LAST Junius Hunt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Graves			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-84-2467		17. INFORMANT Joyce Cowan-Same as # 13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uroperic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Organic Brain Syndrome</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>9/18</u> , 19 <u>86</u> , to <u>1/6</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>1/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Don H. Yablonski</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonski, MD</u>		22e. ADDRESS <u>10300 Greenbelt Rd, Seabrook, Md. 20706</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>1/10/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM. CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SUITLAND P.G. MD.</u>	
24. FUNERAL DIRECTOR NAME <u>H.S. WASHINGTON & SONS</u>				25a. DATE REC'D BY REGISTRAR <u>JAN 30 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Kendall</u>	



BP

DHMH - 16 60M 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE IN PRINT) ARLENE R. SEWARD			2a. DATE OF DEATH MONTH 01 DAY 19 YEAR 87		2b. HOUR 9:35 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH Feb. DAY 14 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper - Ret.	
13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Walter MIDDLE LAST Rager			15. MOTHER'S MAIDEN NAME FIRST Mabel MIDDLE LAST Adkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 163-12-3808		17. INFORMANT ADDRESS Walter S. Seward 4915 Sharon Rd. Temple Hills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF (b) LANGE'S CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PORTAL HYPERTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1119 , 19 87 , to 1119 , 19 87 , that (I) (we) last saw the deceased alive on 1119 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE SA W. C. W. C.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/20/87	
22d. PHYSICIAN'S NAME (TYPE IN PRINT) GURBOX NACHWANI		22e. ADDRESS 20735 MD RD CLINTON			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN Suitland		COUNTY P.G.		STATE Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 21 1987
					25b. REGISTRAR'S SIGNATURE Frederick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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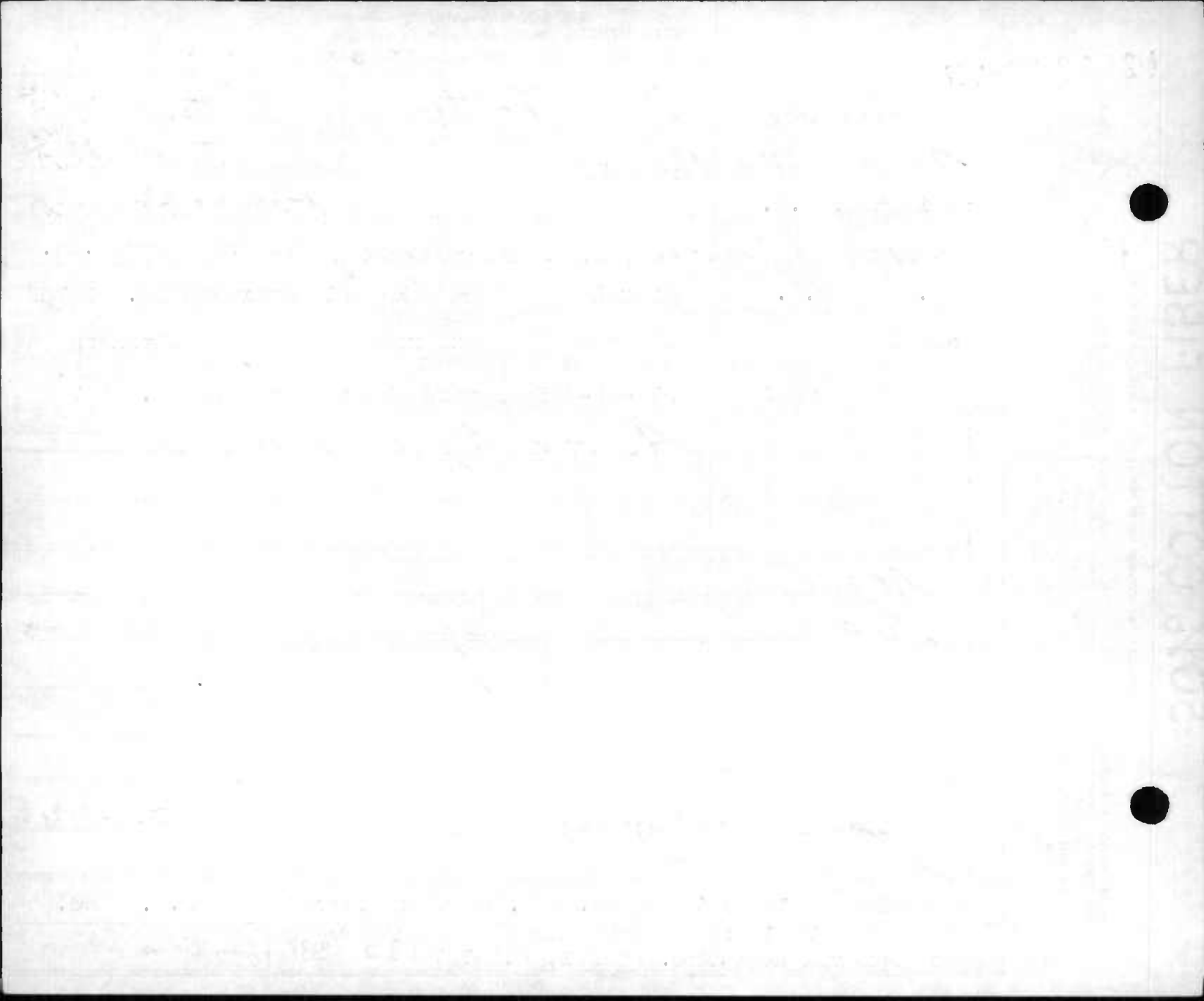
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 2 3 9 7
REG. NO.

FOR STATE REGISTRAR						DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 02891	
1. DECEASED NAME (TYPE OR PRINT) Melvin E Shelton						2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> JAN 19 87 2b. HOUR A MIN M							
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR May 12 19 69		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Jan 27 19 87 2d. HOUR A MIN M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Laurel				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman				12b. KIND OF BUSINESS OR INDUSTRY Truck Co.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9514 Muirkirk Rd. 20708					
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Shelton						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Clarkson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES yes WWII				16b. SOCIAL SECURITY NO. 579-05-0056		17. INFORMANT ADDRESS 8901 Matthews Ct. Edward Shelton Laurel, Md. 20708							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dist DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) DATE SIGNED Jan 27 1987													
ACTUAL SIGNATURE [Signature] M.D. Dep. MEDICAL EXAMINER				ADDRESS _____									
EXAMINER'S NAME (TYPE OR PRINT)													
23a. BURIAL, CREMATION, REMOVAL Cremation				23b. DATE 1/28/87		23c. NAME OF CEMETERY OR CREMATORY Balto.Wash.Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.			
24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc.				7601 Sandy Spring Road Laurel, Md. 20708				25a. DATE REC'D BY REGISTRAR FEB 3 1987				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



40826 JAN 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

02090

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH P. SHEPPARD			2a. DATE OF DEATH MONTH DAY YEAR January 2, 1987		2b. HOUR 1:10A.M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 17, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY education
13a. STATE MD		13b. COUNTY Washington	13c. CITY OR TOWN DC	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Pierson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Turner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-42-4907		17. INFORMANT Anne Noyes	
				ADDRESS 908 Queens Terrace Fort Washington DC.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Massive anterior myocardial infarct (c) Severe atherosclerosis					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1-2					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/30/86 8:15 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-2 87th St. Falls Church VA	
22a. I certify that (I) (this hospital) attended the deceased from 1-2 87th St. to 1-2 87th St. , that (he) (we) last saw the deceased alive on 1-2 87th St. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) not view the body after death).					
22b. SIGNATURE Robert E. Wilhelm		DEGREE MD		22c. DATE SIGNED 1/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B G Manekual		22e. ADDRESS 14201 Laurel Park & Laurel Rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5Jan1987	23c. NAME OF CEMETERY OR CREMATORY National Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE PK Falls Church VA	
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home 4308 Suitland Rd. Suitland, MD.			25a. DATE REC'D. BY REGISTRAR JAN 12 1986		
			25b. REGISTRAR'S SIGNATURE John D. ...		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top portion of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

999999
FORM 10-60M 7/84
(VRA 15, 4)

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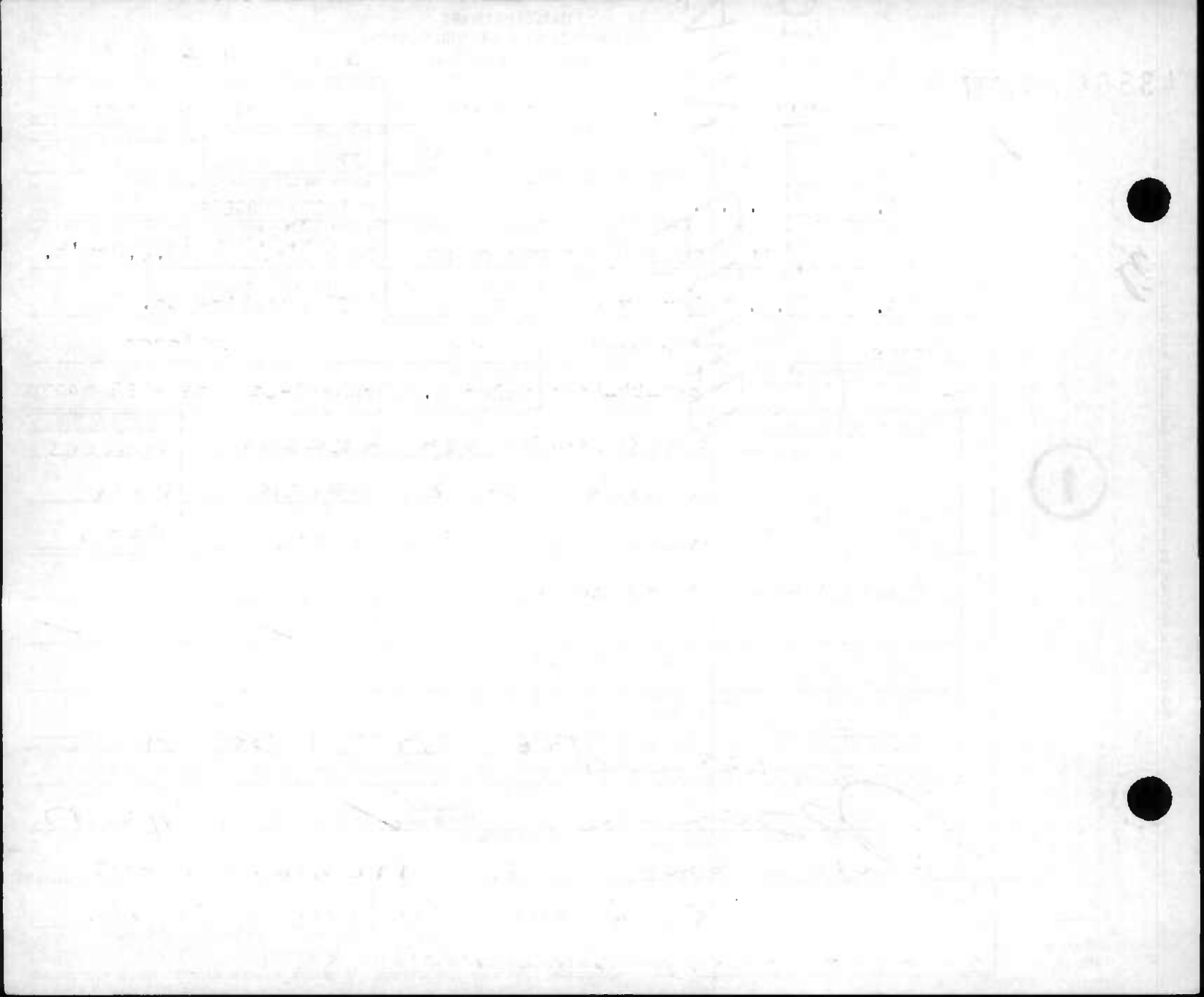
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "other" on page 18, the medical examiner must be notified of this event.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8702899
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM A. SHEPHERD			2a. DATE OF DEATH MONTH DAY YEAR 01 28 87			2b. HOUR 11 05P M		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 03 04 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.		
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Shepherd		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Robinson		13e. STREET ADDRESS / ZIP CODE 8808 Sterling St. 20784				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-44-4171		17. INFORMANT ADDRESS Helen M. Shepherd-Same as # 13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GRAM NEGATIVE SEPSIS</u> <u>DAYS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCENDING CHOLANGITIS</u> <u>DAYS</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ALCOHOLIC CIRRHOSIS</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>87</u> to <u>1/28</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>George Bone</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/30/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GEORGE BONE</u>				22e. ADDRESS <u>8101 ALKING ST. HWY</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>2/2/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>CLINTON P.G. MD.</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 9 1987</u>		25b. REGISTRAR'S SIGNATURE		



42576 FEB-20

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, immediate coroner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02900

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wayson A Siebel			2a. DATE OF DEATH MONTH DAY YEAR 01 18 87		2b. HOUR 9 ³² AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 05 07		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Fort Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ft. Washington Rehabilitation Ctr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Farmer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. COUNTY AA	13d. CITY OR TOWN West River	13e. STREET ADDRESS / ZIP CODE 4874 Sudley Road 20718	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Seibel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Wayson		ADDRESS Samalas #113	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT Calprunia S. Carter.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH #113	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Nazemian		DEGREE		22c. DATE SIGNED 1-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 12021 Livingston Rd., Ft. Washington, MD 20744			
23a. BURIAL, CREMATION, REMOVAL (BY)	23b. DATE Jan 21, 1987	23c. NAME OF CEMETERY OR CREMATORY Mt Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Lathian AA MD	
24. FUNERAL DIRECTOR NAME Zylor Funeral Chapel / Anneapolis		25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

1994

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02901

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH L. SLAYMAKER			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1987		2b. HOUR 12:45PM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 13 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS CITY MO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CAMP SPRINGS, PRINCE GEORGE	
10. CITY OR TOWN OF DEATH CAMP SPRINGS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8312 BERNARD DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY PG		13c. CITY OR TOWN CAMP SPRINGS		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET ADDRESS / ZIP CODE 8312 BENARD DRIVE		14. FATHER'S NAME FIRST MIDDLE LAST GEORGE SPEARS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN WILSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 499-18-3418		17. INFORMANT ADDRESS RICHARD P. SLAYMAKER SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Cancer</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>metastatic disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>metastatic disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>Summer 86</u> to <u>Jan 14, 87</u> , that (I) (we) last saw the deceased alive on <u>Dec. 27</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>James F. Barter M.D.</u>		DEGREE		22c. DATE SIGNED <u>1/15/87</u>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS					
<u>James F. Barter M.D.</u>		<u>LOMBARD CANCER INST.</u> <u>GEORGETOWN UN. HOSP.</u> <u>WASH. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/16/87		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG MARYLAND	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>1/20/87</u>		<u>[Signature]</u>					

ROBERT E. WILHELM FUNERAL HOME
4308 SUITLAND ROAD SUITLAND MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section paper. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

001500 003100

200% COTTON FIBER



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **02902**

1. DECEASED NAME (TYPE OR PRINT) FIRST RODNEY MIDDLE L. LAST SLOAN										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 4 19 87		2b. HOUR 3:25 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 40		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 4 19 87		7d. HOUR 3:25 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <input checked="" type="checkbox"/> MD.				7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.				8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Laurel				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 Main St.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Laurel 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS 600 Main St. 20707															
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 1-4- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) House fire.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 600 Main St., Laurel, Prince George's, MD							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Charles P. Kokes						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 1-4-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.						ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.						25a. DATE REC'D. BY REGISTRAR JAN 21 1987				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNION CITY

1013 NORTH 200

SLYEM

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02903

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred G. Slye			2a. DATE OF DEATH MONTH DAY YEAR 1-26-87			2b. HOUR 8:45p.m.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-21-1912		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4911 Powder Mill Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. STATE 13b. COUNTY P. G. 13c. CITY OR TOWN Beltsville			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4911 Powder Mill Rd. Beltsville 20705					
14. FATHER'S NAME FIRST MIDDLE LAST Howard Barker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Kelly			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 220-09-0093	
17. INFORMANT ADDRESS Rev. Granville Slye same as 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Conjunctive Head Pains</u>										
19a. DATE OF OPERATION <u>12/11/86</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Conjunctive Head Pains</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR <input type="checkbox"/> AT HOME			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <u>the deceased</u> attended the deceased from <u>12/11</u> 19 <u>86</u> to <u>1/21</u> 19 <u>87</u> , that <u>we</u> lost <u>above</u> <u>the</u> (we) <u>did</u> (did not) view the body after death.										
22b. SIGNATURE <u>Donna R. Schumacher MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna R. Schumacher MD			22e. ADDRESS 14201 Laurel Park Dr. #102 Laurel MD 20707							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/87		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince George Md.				
24. FUNERAL DIRECTOR Donald V. Borgwardt			400 Powder Mill Rd. Beltsville, Md. 20705			25a. DATE REC'D. BY REGISTRAR FEB 2 1987		25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>		


DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



4 0 5 8 9 JAN 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 0 2 9 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERNARD Lee SMITH			2a. DATE OF DEATH MONTH DAY YEAR January 7, 1987			2b. HOUR 6:25a_M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Handyman		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3400 Dodge Park Rd. T-2 20785	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-14-9609		17. INFORMANT ADDRESS Lillian A. Watson, Same as Line #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

*multiple stroke*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

arteriosclerotic heart disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>86</u> , to <u>1/7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Riad Dakheel</i> M.D.				DEGREE M.D.		22c. DATE SIGNED <u>1/7/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel, M.D.				22e. ADDRESS 14300 Galbut Fox Ln. Bowie, MD 20715			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-10-87		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 22 is signed, any injury, or other traumatic event, the medical examiner must be notified at once.

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040731 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

02405

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA V. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 01-03-87		2b. HOUR 2.50A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 24, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS 83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GEN. HOSPITAL & MED. CTR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Pr George		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William E. JENKINS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cassie Brightwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Wilbur G. Smith 305 Durham Drive Fredericksburg, Va				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multi system failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive disease & Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Arteriosclerosis, Aortic Aneurysm, Stroke</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/86</u> 19 <u>86</u> , to <u>1/2</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Robert J. Genciga</u>				DEGREE <u>D.O.</u>		22c. DATE SIGNED <u>1/3/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J Genciga				22e. ADDRESS 410 74th Ave. Landover Heights, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Denton-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1870

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040916 JAN 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02900

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			MONTH DAY YEAR			2c. HOUR						
David Marvin Smith						Jan 11, 1987			10:01			P.M.						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR						
M	W	Jan 10 10	77 YRS.			Jan 11, 1987			10:01			P.M.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH						
West Virginia			US			WIDOWED			DIVORCED			Prince Georges County MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Laurel			Greater Laurel-Beltsville Hosp.			machinist			pvt industry									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
MD			Prince Georges			Beltsville,			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4705 Sellman Rd 20705						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
David C. Smith			Bertha Pyle			234-09-7249			Betty M. Smith same as #13									
16b. WAS DECEASED EVER IN U.S. ARMED FORCES?			16c. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			234-09-7249			Betty M. Smith same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>																		
DUE TO, OR AS A CONSEQUENCE OF																		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		
(b) <u></u>																		
DUE TO, OR AS A CONSEQUENCE OF																		
(c) <u></u>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																		
<u>None</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
<u>None</u>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
			HOUR A.M. MONTH DAY YEAR															
			P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																		
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED									
<u>[Signature]</u>			M.D. <u>Depp</u>						Jan 12, 1987									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN			COUNTY		STATE	
Burial			1/15/87			George Washington			Adelphi			Prince George Md						
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
Donald V. Borgwardt			4400 Powder Mill Rd. Beltsville Md 20705			JAN 16 1987												

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PMI 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

040101040



042630 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon pages 1 and 2 and place them in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

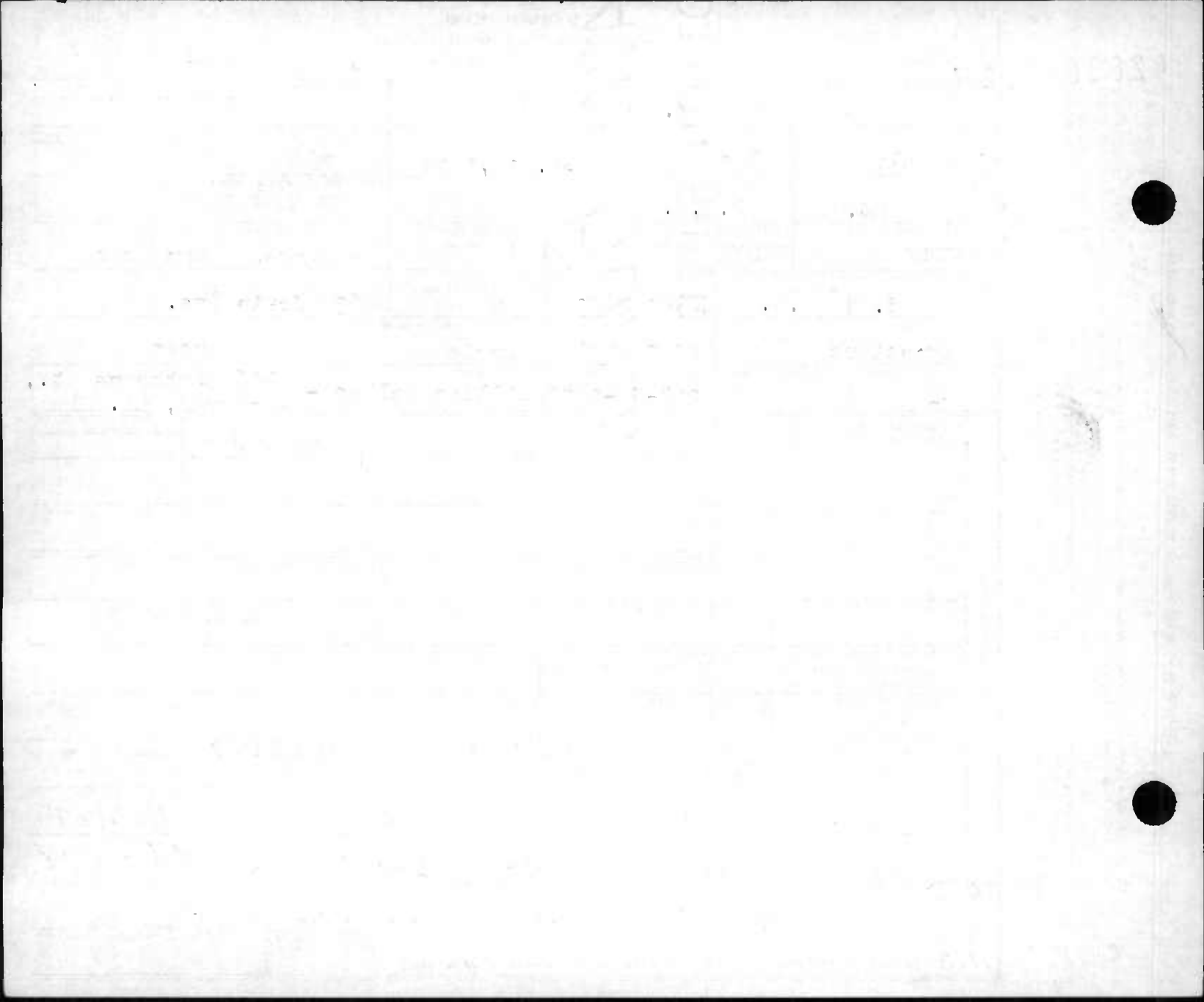
BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 02901

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. SMITH		MONTH DAY YEAR 01-24-87		12 00AM M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Md.		13b. COUNTY P.G.	13c. CITY OR TOWN Glen Arden	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ignatious Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Queen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-58-1740		17. INFORMANT ADDRESS Lillian Wallace- 7406 Hawthorne St., Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/15/87, 19, to 1/23/87, 19, that (I) (we) last saw the deceased alive on 1/22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gita K. Shah MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GITA K. SHAH MD		22e. ADDRESS 14333 LAUREL/BOWIE Rd. 20708			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE 1/29/87	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON P.G. MD.
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS		ADDRESS 4925 BIRD LIGHT AVE. W.		25a. DATE RECEIVED BY REGISTRAR JAN 30 1987	
				25b. REGISTRAR'S SIGNATURE	



041920 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 02908

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELAINE D SNOOTS			2a. DATE OF DEATH MONTH DAY YEAR 01 20 87			2b. HOUR 2 40 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 14 32		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN LANDOVER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WARREN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMEN MILLER		13e. STREET ADDRESS / ZIP CODE 6111 OTIS ST. 20785			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 212-68-6863		17. INFORMANT ADDRESS WILLIAM F. SNOOTS (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> 19 <u>87</u> to <u>1-20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Sankar Nayar</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-20-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. M. NAYAR, MD				22e. ADDRESS 3717 38 th AVE BRENTWOOD MD 20721			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-24-1987		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Tindon-Randall</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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043619 FEB 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02909

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Maude		M.		Solomon				1-28		19		87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	12-14-1889		97 YRS.						1-28		19		87		10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Emporia, Kansas		United States		WIDOWED		X		DIVERCED		Prince Georges						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Clinton		Southern Maryland		School Teacher		Education											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE (CITY LIMITS)?		13e. STREET ADDRESS									
Maryland		Prince Georges		Marlow Heights		YES X NO		3610 Riviera St. 20748									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
William		Mary		No		412-78-4229		(Sister)		Marlow Heights,							
				N/A				Lillian Hall.		3610 Riviera St. Maryland.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
7 8842		Right hip fracture with complications															
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
4-27-87		Right hip fracture		YES NO													
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		8:00 P.M. 1-28-87		Fall from chair													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHILE AT WORK NOT WHILE AT WORK		Home		3610 Riviera St. Marlow Heights, Md. (George Hill)													
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Augusto P. Rodriguez		M.D.		1/28/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Augusto P. Rodriguez MD		509 Rayburn Court, Bay Springs, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. COUNTY		23f. STATE							
Burial		2-1-87		Highland Cemetery		Chattanooga, Tenn		Hamilton, Co.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
J. William Lee's Sons Company																	
300-4th St. N.E. Washington, D.C. 20002																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN BRACKET ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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040212 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02910

1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Betty Ann Stallings										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 1-1 19 87		2b. HOUR					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1945		6. AGE (IN YEARS) LAST BIRTHDAY 41 YRS.		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD 1-1 19 87		2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Suitland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife				12b. KIND OF BUSINESS OR INDUSTRY n/a					
13a. STATE Maryland										13b. COUNTY P.G.		13c. CITY OR TOWN Forrestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Surrey Square 20747	
14. FATHER'S NAME FIRST MIDDLE LAST Edward J Fowler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice A. Stallings													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a				17. INFORMANT Gorman Stallings Same as #13				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 1-1-87									
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE Jan 4, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. harmony Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Owings Calvert Maryland							
24. FUNERAL DIRECTOR NAME Rausch Funeral Home				ADDRESS Owings Maryland				25a. DATE REC'D. BY REGISTRAR JAN 6 1987				25b. REGISTRAR'S SIGNATURE Julia Fenderson-Randall					

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardmounts. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 7 0 2 9 1 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA HENDRICKS STEPPE			2a. DATE OF DEATH MONTH DAY YEAR January 14 1987		2b. HOUR 1145 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 01-27-1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Aid.		12b. KIND OF BUSINESS OR INDUSTRY Medical
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Charles Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1106 Stone Ct. 20601		
14. FATHER'S NAME FIRST MIDDLE LAST Barney O. Hendricks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Floria D. Steel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Fred A. Steppe Jr. Same as Blk. 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest sec. to Asar DUE TO, OR AS A CONSEQUENCE OF (b) COPD and respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 86 to present 19____, that (I) (we) lost saw the deceased alive on 1/13/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Annette C. Gonsalves</i>		DEGREE MD		22c. DATE SIGNED 1/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Annette C. Gonsalves		22e. ADDRESS 6 Post Office Rd. Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-17-87	23c. NAME OF CEMETERY OR CREMATORY Ft. Hill Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Lynchburg Campbell Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Huntt F.H. Inc. Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR JAN 19 1987			
		25b. REGISTRAR'S SIGNATURE <i>Julia Lindon Rucker</i>			

BP

Item # 1, film G 624, 2/20/87 ra

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02912

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Earl Stout		2a. DATE OF DEATH January 30, 1987		2b. HOUR 11:26 A.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH January 7, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5506 Farragut Street		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Heavy Equipment			

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Harry L. Stout		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Hurbert		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-2048		17. INFORMANT 3911 Church Road Harry Stout (Son) Mitchellville, Md. 20716	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAUDIAL ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SYNS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>central vascular disease</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1-21</u> 19 <u>87</u> to <u>1-21-87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Rogers</u>		22c. DATE SIGNED 1-31-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER B. INGHAM M.D.		22e. ADDRESS 6510 KENILWORTH AVE., RIVERDALE, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/04/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		23e. DATE REC'D. BY REGISTRAR FEB 6 - 1987		23f. REGISTRAR'S SIGNATURE <u>Julia Swenson</u>	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781					



United States of America

Washington, D.C.

January 1, 1900

Very Respectfully,

Robert B. Heald

RECEIVED

042283

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02913

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John William Straub			2a. DATE OF DEATH MONTH DAY YEAR January 21, 1987		2b. HOUR 9:35P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Payroll Accountant		
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel N. Straub		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah NaPier		13e. STREET ADDRESS / ZIP CODE 3324 Gumwood Drive 20783	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 225-05-1023		17. INFORMANT (Brother) ADDRESS Samuel N. Straub 4316 Southwest Charlestown Seattle, Washington 98116	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, CHF, Peripheral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure; Anemia - Diabetic Mellitus; 9/p Myocardial Ischemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-20-87 to 1-21-87, that (I) (we) last saw the deceased alive on 1-20-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Villamor S. Reyes		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VILLAMOR S. REYES		22e. ADDRESS 6501 Landover Rd. Chelvy MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/26/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE New Cumberland York Pa.
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR JAN 28 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

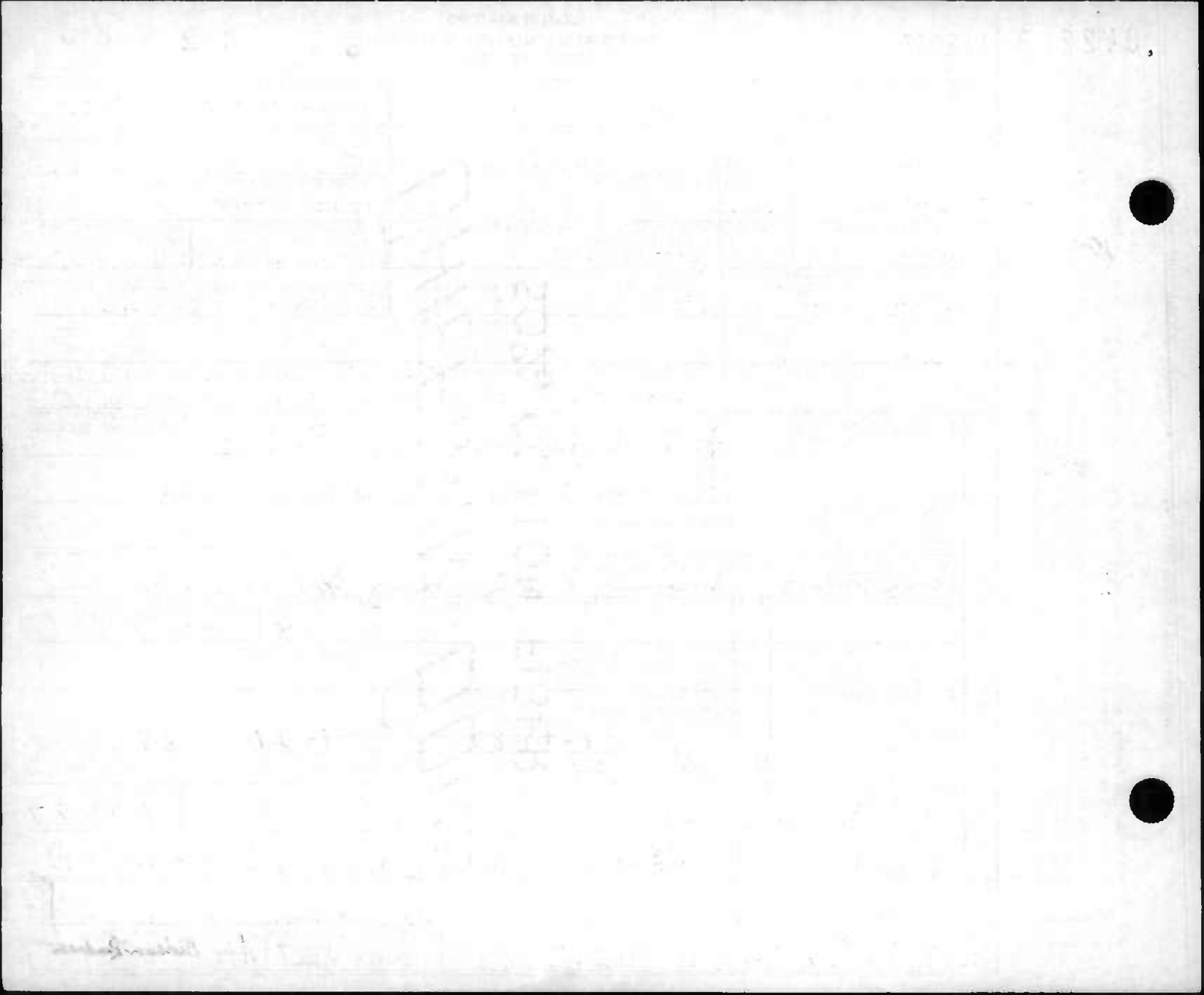
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MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02914

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA V STRINGFIELD			2a. DATE OF DEATH MONTH DAY YEAR 01 11 87		2b. HOUR 3:55 P.M.
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 29 01		6. AGE (IN YEARS (LAST BIRTHDAY)) 85	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3589 Whiskey Bottom Rd. 20707
14. FATHER'S NAME FIRST MIDDLE LAST Edward Cooper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-6337		17. INFORMANT ADDRESS Laurel MD 3587 Whiskey Bottom Rd.	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUDDEN CARDIAC DEATH</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 4/11 19 87, to 4/11 19 87, that (1) (we) last saw the deceased alive on above, (2) (we did) did not view the body after death.					
22b. SIGNATURE G. A. Compton MD		DEGREE MD		22c. DATE SIGNED 1-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. A. Compton MD		22e. ADDRESS 4201 Laurel Park Dr #221 Laurel MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-16-87	23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Anne Arundel, MD	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St Rockville, MD 20850		25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Borden-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders' pages, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

02915

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH		DAY			
MICHAEL Joseph SWEENEY			01-05-87			8 38AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Male		Caucasian		February 15, 1899		88		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		U.S.A.				PRINCE GEORGE'S MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY		PRINCE GEORGE'S HOSPITAL CENTER				Mechanic		Bakery			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Charles			Bryans Road			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.	
Mathew J. Sweeney			Jessie M. Fowler			Yes				06/11/19	
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>			19. DATE OF OPERATION				19a. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Michael D. Sweeney			DUE TO, OR AS A CONSEQUENCE OF			20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Woodbridge Va 22191			(b) <u>Pneumonia</u>			YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>	
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Isaemic heart disease</u>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. SIGNATURE		
			HOUR A.M. MONTH DAY YEAR						David M. Goldman M.D.		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			22c. DATE SIGNED		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN STREET			1-5-87		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> 19 <u>80</u> to <u>1/5</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		
David M. Goldman			1-5-87			David M. Goldman M. D.			7500 Hanover Pkwy. #105 Greenbelt, Md 20770		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			01/08/87			Maryland Veterans Cem			Cheltenham Md Prince George's		
24. FUNERAL DIRECTOR			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE		
Lee Funeral Home, Inc.			JAN 16 1987			Julia Davidson-Rachin					
16633 Old Alexander Ferry Road Clinton, Md 20735											

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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041398 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 02916

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA H. TALBOT			2a. DATE OF DEATH MONTH DAY YEAR 01-16-87		2b. HOUR 1.55A M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR March 13, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Prince George	13c. CITY OR TOWN Cheverly	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter Hooper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia C. Hamill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 8574		17. INFORMANT ADDRESS Mrs. Ann T. Miller Cheverly, Md. 20785	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MILD REGURGITATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROBABLE RHEUMATIC HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u> <u>YEARS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>INTERSTITIAL LUNG DIS FROM TUBERCULOSIS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (in this hospital) attended the deceased from 1/15/87 to 1/15/87, that (we) last saw the deceased on 1/15/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>[Signature]</u>		22c. DATE SIGNED 1/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. SCHLOSSER M.D.</u>		22e. ADDRESS <u>7500 GREENWAY DR. BALTIMORE MD 21220</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/19/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 20 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



040696 JAN 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FILED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02911

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Henry John Tass			JAN 5 1987			7:30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Male	White	9-30-1911	75 YRS.			JAN 5 1987 7:30 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITY, STATE, AND COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.		U.S.A.				Prince George's MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Leland Memorial Hospital		Carpenter		Construction		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland		Prince George's		Mt. Rainier		3731 Queens Chapel road #102		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		
John V. Tass				Stella Cijija		577-05-5075-A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				17. INFORMANT		3410 Dodge Park Road #102		
No				John W. Tass		Landover, Md. 20785		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic C.O.P.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
				CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
EXAMINER'S NAME			M.D.			MEDICAL EXAMINER		
(TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		1/9/87		Ft. Lincoln Cemetery		Brentwood, Prince George's, Md.		
24. FUNERAL DIRECTOR				25. DATE RECEIVED BY REGISTRAR		26. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781				JAN 13 1987		Julia Gordon-Randall		

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1944-2-20-10

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 0 2 9 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Luka Taylor</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 23 87</i>		2b. HOUR <i>5:30 PM</i>
3. SEX <i>F</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 14 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>P. G. C. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGE</i> MD.	
10. CITY OR TOWN OF DEATH <i>Clinton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Clinton Convales. Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House-wife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>md</i>		13b. COUNTY <i>P. G.</i>	13c. CITY OR TOWN <i>Clinton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Edward Parker</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Simms</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>228-03-5676</i>		17. INFORMANT ADDRESS <i>Elaine Parker Box 125-C Prince Frederick, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>1/24/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 30, 87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brown's Church Cemetery Port Republic Calvert Md</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECD. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME <i>Spencer E. Sewell</i>		ADDRESS <i>Box 31 Prince Frederick, Md</i>		25. REGISTRAR'S SIGNATURE <i>Julia Tindon-Rodgers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified of cause.

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CHIEF



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

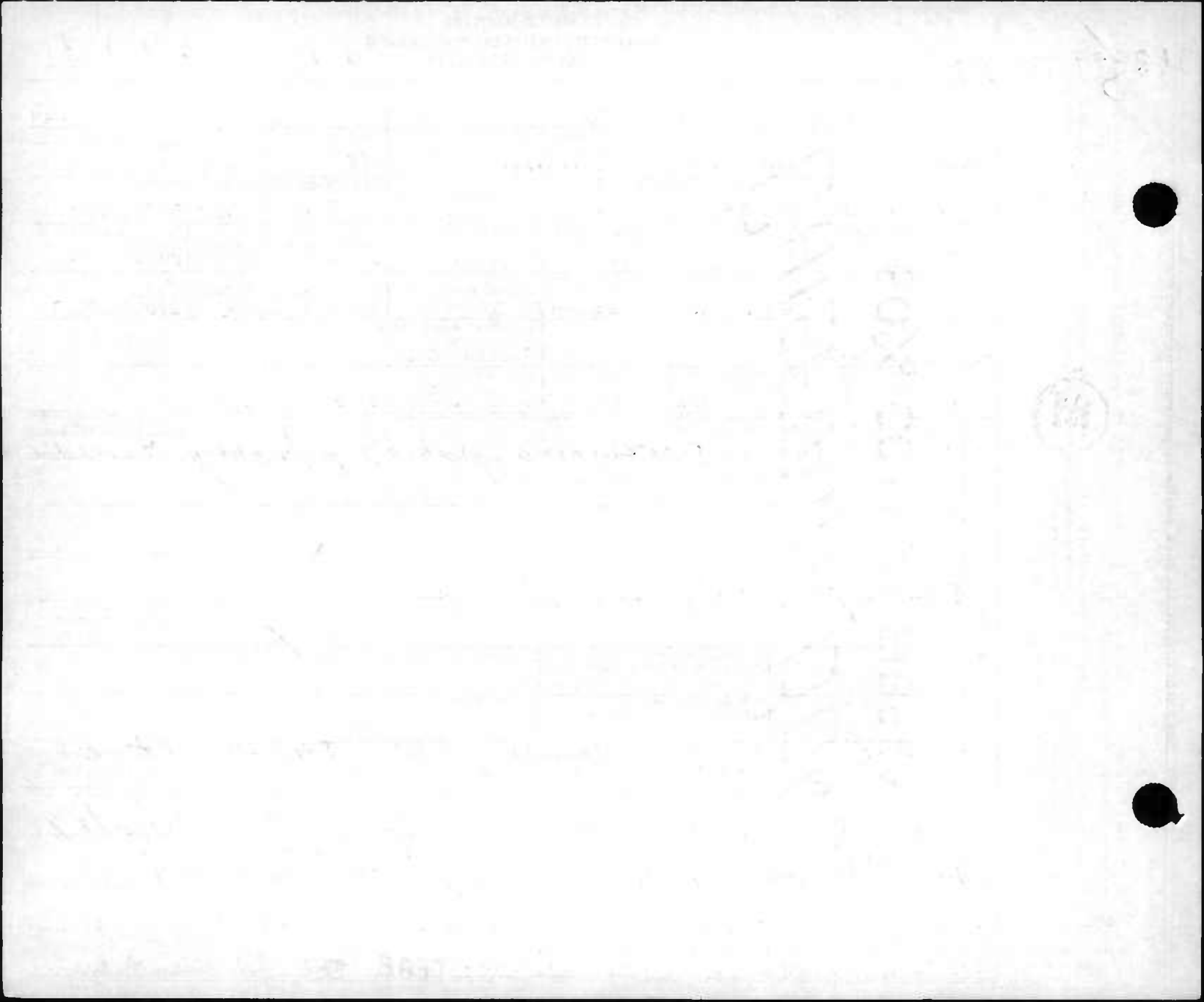
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ROBERT		C.		TAYLOR				1-29-87								4:15 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Caucasian		7/21/17		69		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
North Carolina		U.S.A.				PRINCE GEORGES COUNTY MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
CLINTON		SOUTHERN MARYLAND HOSPITAL		Retired		Post Office											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
Maryland		Pr. Geo.		Upper Marlboro				10816 Hollaway Drive		20772							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Robert C. Taylor		Jessie Cain															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		218-05-9091		Cecil C. Taylor		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Carcinoma, probably pulmonary				4 weeks											
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Severe peripheral vascular disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (1) (this hospital) attended the deceased from Jan 17, 1987, to Jan 29, 1987, that (two) last saw the deceased alive on Jan 29, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED											
		Ronald - Lunsford M.D.		M.D.		1/30/87											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Ronald Lunsford M.D.		9440 Pennington Ave.		Upper Marlboro Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		2/2/87		Ft. Lincoln Cemetery		Brentwood, Prince George's, Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Francis Gasch's Sons Funeral Home, P.A.		FEB 6 - 1987		Julia Tidwell-Burrows													
4739 Baltimore Avenue Hyattsville, Md. 20781																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.



040714 JAN 14

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR HOUR				
JOSEPH S. TEMPLEMAN					01 01 87 6:56p M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		BLACK		MONTH DAY YEAR SEPT. 5, 1917		69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		UNITED STATES				PRINCE GEORGES COUNTY MD			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
CLINTON		SOUTHERN MARYLAND HOSPITAL		GOVERNMENT EMP.		GOVERNMENT			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					17. STREET ADDRESS / ZIP CODE				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MARYLAND CHARLES NEWBURG					P.O. BOX 131-M6 / 20664				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
SEMON TEMPLEMAN					ESTELL MIDDLETON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
NO N/A					212-16-5266A				
17. INFORMANT ADDRESS					P.O. BOX 131-M6				
DELORES A. TEMPLEMAN - NEWBURG, Md.					20664				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONGESTIVE HEART FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> 19 <u>87</u> , to <u>1-1-</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-1-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Raj Samtani</u> DEGREE <u>MD, FAC</u>					22c. DATE SIGNED <u>1-3-86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RAJ, SANTANI, M.D. FAC</u>					22e. ADDRESS <u>7301 SURREYS RD Clinton MD 20731</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		JAN. 6, 1987		HOLY GHOST CHURCH CEM.		ISSUE CHARLES Md.			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
THORNTON'S FUNERAL HOME POMONKEY, Md.					JAN 8 1987 <u>Julia Anderson</u>				

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040134 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02921

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Daniel Joseph Thomas		Male		Caucasian	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD	
July 16, 1913		73 YRS.		1-2 1987	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		Prince George's	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Camp Springs		Malcolm Grow Medical Center		Supervisor - Ret. U.S. Post Off.	
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince George's		N. Forestville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
David		Cora		2615 Overdale Pl.	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INFORMANT	
Yes		WWII		Beatrice M. Thomas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u>		19. DATE OF OPERATION		20. AUTOPSY?	
DUE TO, OR AS A CONSEQUENCE OF				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
				HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>1-3-87</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u>		ADDRESS <u>5009 Rayburn Ct. Temple Hills, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/6/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
24. FUNERAL DIRECTOR NAME <u>George P. Kalas Funeral Home</u>		ADDRESS <u>Oxon Hill, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 5 1987</u>	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

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41927 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02922
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: Lewis LAST: Thomas		2a. DATE KNOWN OF DEATH MONTH: 1 DAY: 12 YEAR: 87		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH: MAR DAY: 31 YEAR: 28	6. AGE (IN YEARS) 58 YRS.	IF UNDER 1 YR. MONTHS: DAYS: HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH P.G. Co. MD.
10. CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 4691 Homer Avenue APT D		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JANITOR
13a. STATE MD.		13b. COUNTY PG.	13c. CITY OR TOWN SUITLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST: FRANK MIDDLE: W. LAST: THOMAS		15. MOTHER'S MAIDEN NAME FIRST: ALBERTA MIDDLE: CLARK LAST: CLARK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 578-42-8708	17. INFORMANT ALICE THOMAS ADDRESS: 4735 HURON AVE SUITLAND MD.	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empyema</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez M.D. Deputy		TITLE (SPECIFY) MEDICAL EXAMINER		DATE SIGNED 1-12-87
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D.		ADDRESS 5009 Rayburn Ct. Cp Spr. Pr Geo. Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-19-87	23c. NAME OF CEMETERY CHELTENHAM CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS ROLLINS FUNERAL HOME 4339 HUNT PL. WASH. D.C.		25a. DATE REC'D. BY REGISTRAR JAN 27 1987	25b. REGISTRAR'S SIGNATURE Julia Frederick-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERMENT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1-12-37
1-12-37

John ...

AS IS

W.A.A.

SHIPPING
ORDER

RECEIVED

1001 WEST AVE

STATION

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ST.

CLERK

ADDRESS

THREAT

ST.

ST.

200-42-1000 1000 WEST AVE

Enclosed



1-12-37

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1-12-37

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

043224

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02923
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Caroline THOMAS			2a. DATE OF DEATH MONTH DAY YEAR 01 27 87		2b. HOUR 12:35 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 07 09 1881		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HRS. MIN. 105 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE George's MD		
10. CITY OR TOWN OF DEATH Chinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Music Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Prince Geo		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jerry Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Craiggs		13e. STREET ADDRESS / ZIP CODE P.O. Box 243 20613			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Charles Thomas SAA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RLC pneumonia & Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Alcohol Dehydration								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-24-87 to 1-27-87 , that (I) (we) lost saw the deceased alive on 1-27-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-27-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN, U. ANSARI		22e. ADDRESS 8926 Woodley and Road #101 Clinton Md 20735						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/'87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath Ch		23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown, Chas. Md		
24. FUNERAL DIRECTOR NAME Marlett Adams, Aguasco Md		25a. DATE REC'D. BY REGISTRAR FEB 6 1987		25b. REGISTRAR'S SIGNATURE [Signature]				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 02924

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND E. THOMAS			2a. DATE OF DEATH MONTH DAY YEAR 01 18 87			2b. HOUR 6PM M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Laundry	
13a. STATE Md.		13b. COUNTY P.G. Chapel Oaks		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 5001 Nash St. 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Thomas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-18-1816		17. INFORMANT ADDRESS Mattie S. Thomas-Same as # 13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RUPTURED APPENDIX & PERITONITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPER TENSION</u>							
19a. DATE OF OPERATION 1/15/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Appendix		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-14 19 87 to 1-18 19 87, that (I) (we) lost saw the deceased alive on 1-18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE K. S. Mathew		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.S. MATHIEW		22e. ADDRESS 6510 Kenilworth Ave Riverdale, Md 20737					
23. BURIAL (CEREMONY) CREMATION, REMOVAL		23b. DATE 1/24/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G., MD.	
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON + SONS		ADDRESS 4925 BURNING WOOD AVE, N.E.		25a. DATE RECEIVED BY REGISTRAR JAN 30 1987		25b. REGISTRAR'S SIGNATURE Julius Davidson-Randall	

BP

042311 JAN 23 1987

DIVISION OF VITAL RECORDS, 201 WM. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WM. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02925
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
John I. Thompson		1-24 1987		87	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. DATE PRONOUNCED DEAD	8. BALTIMORE CITY OR COUNTY OF DEATH
Male	White	3-10-28	58 YRS.	1-24 1987	Prince George's County MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. NEVER MARRIED	10. CITY OR TOWN OF DEATH	
Pennsylvania	USA	<input checked="" type="checkbox"/> MARRIED	<input type="checkbox"/> NEVER MARRIED	Bowie	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bowie Health Center		Computer Scientist		Computers	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Pr. George's	Bowie	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12501 Kensington Lane 20715	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
John I. Thompson, Sr.		Catherine Schmidt		151-20-9333	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
YES		Phyllis I. Thompson		INTERMITTENT CARDIOVASCULAR DISEASE	
WW II		Bowie, MD 20715		PART 1 DEATH WAS CAUSED BY:	
				IMMEDIATE CAUSE (a)	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b)	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		Deputy		1-25-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct, Temple Hills, MD	
Augusto P. Rodriguez, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY STATE	
Burial	JAN 29, 1987	Maryland Veterans Cem.	Cheltenham	Pr. George's, MD	
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Beall Funeral Home	JAN 28 1987		Julia Danden-Randall		

07/84
25A

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DHMH - 17
(VR A15 ME (5))

042953 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02920
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KAREN E. THOMPSON										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-19-87 19		2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 1-19-87 19		2d. HOUR 3:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Temple Hills				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4507 23rd Parkway Apt. 304				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Specialist				12b. KIND OF BUSINESS OR INDUSTRY US Gov't			
13a. STATE MD				13b. COUNTY Pr. Geo		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4507 23rd Pkwy, #304/ 20748					
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Thompson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fay Dunmore									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-74-1570				17. INFORMANT 1914 Valley Ter. SE Wilbur Thompson (Brother) Wash. DC 20032							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-20-87							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1-24-87		23c. NAME OF CEMETERY OR CREMATORY Lee Crematorium				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC					
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, MD 20850				25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia Swenson-Rudolph					

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DHMH - 17
(VR A15 ME (5))

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1910-11

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041148 JAN 20 17

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02921
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <i>Margaret M. Thompson</i>			MONTH DAY YEAR <i>1-9-87</i>			2200 ^M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
<i>Female</i>	<i>White</i>	MONTH DAY YEAR <i>Jan. 24, 1922</i>	<i>64</i> YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH			
<i>Washington, DC</i>	<i>U.S.A.</i>				<i>Prince Georges, MD</i>			
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY	
<i>Takoma Park</i>	<i>Washington Adventist Hospital</i>			<i>Housewife</i>			<i>Own Home</i>	
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			17. INSIDE CITY LIMITS?			18. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Maryland Montgomery Chevy Chase</i>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>3407 Coquelin Terr. 20815</i>		
19. FATHER'S NAME FIRST MIDDLE LAST <i>Gates G. Rapp</i>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna McCarthy</i>					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			22. SOCIAL SECURITY NO. <i>578-18-2777</i>			23. INFORMANT ADDRESS <i>Francis G. Thompson (Son) same as # 13</i>		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Liver Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastatic Lung Cancer</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>1 week</i> <i>2 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY?		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9:30 PM 19</i>			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART 1 OR PART 2)		
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE		
35. I certify that (1) this hospital attended the deceased from <i>26 Dec 1986</i> to <i>9 Jan 1987</i> , that (2) I saw the deceased alive on <i>26 Dec 1986</i> , and that in my (my) opinion death occurred on the date and hour and from the causes stated								
36. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. DATE SIGNED <i>1/10/87</i>
38. PHYSICIAN'S NAME (TYPE OR PRINT)			39. ADDRESS					
<i>Thomas H. Bensinger MD</i>			<i>7525 Greenway Ctr Drive Greenbelt MD</i>					
40. BURIAL, CREMATION, REMOVAL (SPECIFY)			41. DATE			42. NAME OF CEMETERY OR CREMATORY		
<i>Burial</i>			<i>Jan. 13, 1987</i>			<i>Arlington National Cem</i>		
43. FUNERAL DIRECTOR NAME			44. ADDRESS			45. DATE REC'D. BY REGISTRAR		
<i>John F. DeVol</i>			<i>2222 Wisc. Ave. NW Wash. DC</i>			<i>JAN 14 1987</i>		
46. REGISTRAR'S SIGNATURE			47. REGISTRAR'S SIGNATURE					
<i>Julia Sanders-Rudner</i>			<i>Julia Sanders-Rudner</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.



040119 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH02928
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth M. Thompson				2a. DATE KNOWN OF DEATH ESTIMATED 1-3 1987			
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1919	6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-3 1987	2d. HOUR 2:15 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS NO BUSINESS MDHC	
13a. STATE MD.				13b. COUNTY P.G.		13c. CITY OR TOWN LANDOVER	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS H. MARSHALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL KEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-24-3165		17. INFORMANT ADDRESS SHIRLEY P. NEWMAN - SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Subacute arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 1-3-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD					
23a. BURIAL, CREMATION, REMOVAL (FOR SIGNATURE)		23b. DATE 1/7/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS H.S. WASHINGTON & SONS 4925 BURROUGHS AVE W.				25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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1967 JAN 2

042421 JAN 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02929
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Eugene Tippet			2a. DATE OF DEATH MONTH DAY YEAR 1 26 87		2b. HOUR 130 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 30 25		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pineview Manor Extended Care Centre		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automobile			
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton	
14. FATHER'S NAME FIRST MIDDLE LAST Owen Tippet			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Virginia Cook			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. na		17. INFORMANT wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Squamous Cell Carcinoma Parotid Gland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Months 4 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CVAE Paralysis, Organic Brain Syndrome						
19a. DATE OF OPERATION 11/26/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 11/26/87		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (was hospital) attended the deceased from 9/12 19 75 to 1/26 19 87 , that (I) (was) last saw the deceased alive on 11/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Thomas D. Feldman MD				22c. DATE SIGNED 1/26/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Prince George's Md		25a. DATE REC'D. BY REGISTRAR JAN 29 1987				
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc Old Alexander Ferry Rd., Clinton, MD 20735				25b. REGISTRAR'S SIGNATURE J. Feldman		

MEDICAL CERTIFICATION

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040163 JAN - 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02930
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alberta M. Tracy			2a. DATE OF DEATH MONTH DAY YEAR 1-2-1987			2b. HOUR 2.35PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04-12-01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-George's County MD.			
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Pr. George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12911 Victoria Heights Drive 20715	
14. FATHER'S NAME FIRST MIDDLE LAST John Lavan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Linott			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 206-40-5107			17. INFORMANT Mary Catherine Huff			17. ADDRESS 12911 Victoria Heights Drive Bowie, MD 20715			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>P. Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis (due to decubitus sacrum.)</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>86</u> , to <u>1-2</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ciro A. Montanez, MD			22e. ADDRESS 3508 Dodge PK Rd - Landover, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b. DATE JAN 7, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover, Luzerne, Pennsylvania		
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 300 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR JAN 7 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02931
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Katie Tucker			2a. DATE OF DEATH MONTH DAY YEAR January 15, 1987		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 03 31 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Mississippi	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Glen Arden	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3116 Brightseat Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Pvt
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P G	13c. CITY OR TOWN Glen Arden	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3116 Brightseat Road 20785
14. FATHER'S NAME FIRST MIDDLE LAST Green West		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie West			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT Bonnie F. Johns 3116 Brightseat Road Glen Arden, Md 20785			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> <u>1987</u> to <u>19</u> <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas R. Parker</i>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas R. Parker				22e. ADDRESS 9970 Armysah Rd Land MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 17 Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
23d. LOCATION CITY OR TOWN Landover		COUNTY PG		STATE Maryland	
24. FUNERAL HOME NAME J.B. Jenkins Funeral Home ADDRESS 7474 Landover Rd			25. DATE REC'D. BY REGISTRAR JAN 21 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please attach both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of the death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02932

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JAMES M. TURKETTE, Sr.

2a. DATE OF DEATH

01-13-87

2b. HOUR
8.20P

3. SEX

Male

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
July 16, 1923

6. AGE (IN YEARS LAST BIRTHDAY)

63

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S County

MD.

10. CITY OR TOWN OF DEATH
CHEVERLY11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
PRINCE GEORGE GENERAL HOSP. & MED.12a. USUAL OCCUPATION
(IF WORK FOR MOST OF WORKING LIFE)
CTR. Repairman12b. KIND OF BUSINESS OR
INDUSTRY
Appliance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Hyattsville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5204 56th Avenue 20781

14. FATHER'S NAME

FIRST
John

MIDDLE

LAST

Turkette

15. MOTHER'S MAIDEN NAME

FIRST
Eva

MIDDLE

LAST

Fraylick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

248-36-0074

17. INFORMANT (Wife)

Sarah L. Turkette

ADDRESS 5204 56th Avenue

Hyattsville, Md. 20781

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

(b) Pneumonia

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

~1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/17, 1986, to 1/13, 1987, that (I) (we) lost
saw the deceased alive on 1/13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

1/14/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

8926 Woodbury Rd Clinton MD

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

01/14/87

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory Alexandria

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Virginia

24. FUNERAL HOME OR OTHER PLACE WHERE DECEASED WAS PREPARED

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR

JAN 19 1987

25b. REGISTRAR'S SIGNATURE

Julia Darden-Randall

1312

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041541 JAN 22 1987

Items # 2a & 22a, G-623 1/27/87 Gbj.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

02933

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI- MATED DEATH			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH		
George Richard Tyfa			Jan 15 1987			Jan 12 1987			Jan 12 1987			Jan 12 1987		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.		
M			Czechoslovakia			Jan 15 1928			58 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Czechoslovakia			USA			NEVER MARRIED			P.G.			Laurel		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS			13b. STREET ADDRESS		
Crestley Laurel Belterville Hall			Auto Mech.			Self.			YES NO			9626 Balto. Ave. 20707		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Vaclav Tyfa			Marie Oliverius			no			218-38-9832			Elizabeth Heckman Tyfa same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS		
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>			None			None			YES NO			21b. TIME OF INJURY		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
						WHILE AT WORK			STREET CITY OR TOWN COUNTY STATE			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an			22b. DATE			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION			22e. DATE REC'D BY REGISTRAR		
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			1/15/87			Ivy Hill Cemetery			Laurel			JAN 20 1987		
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22f. FUNERAL DIRECTOR			22g. DATE OF DEATH			22h. REGISTRAR'S SIGNATURE			22i. REGISTRAR'S SIGNATURE		
ACTUAL SIGNATURE			7601 Sandy Spring Road			Fleck Funeral Home, Inc. Laurel, Md. 20707			JAN 20 1987			JAN 20 1987		
EXAMINER'S NAME (TYPE OR PRINT)			22j. DATE OF DEATH			22k. REGISTRAR'S SIGNATURE			22l. REGISTRAR'S SIGNATURE			22m. REGISTRAR'S SIGNATURE		
			1/15/87			JAN 20 1987			JAN 20 1987			JAN 20 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

04154 1951 40

4 1 6 8 6 JAN 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 9 3 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RHODA		FIRST MIDDLE LAST TZEMACH		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1987		2b. HOUR MIN. 1:56P	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 7 1950		6. AGE (IN YEARS LAST BIRTHDAY) 36	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY	
10. CITY OR TOWN OF DEATH GREENBELT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1925 MANDAN ROAD		12a. USUAL OCCUPATION (TYPING IN SUCH FACTORY (GIVE STREET ADDRESS)) COMMUNICATION REPRESENTATIVE		12b. KIND OF BUSINESS OR INDUSTRY C & P TELEPHONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. CITY OR TOWN PRINCE GEORGE'S		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 7925 MANDAN ROAD 20770	
14. FATHER'S NAME ABRAHAM		MIDDLE SPIELMAN		15. MOTHER'S MAIDEN NAME FRANCES		MIDDLE COHEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 146-42-1502		17. INFORMANT FRANCES SPIELMAN, 234 KEARNEY AVENUE, PERTH AMBOY, NEW JERSEY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) hepatic failure DUE TO, OR AS A CONSEQUENCE OF (c) widely metastatic breast cancer							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/15/86 , 19 86 , to 1/12/87 , 19 87 , that (I) (we) last saw the deceased alive on 1/12/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <i>Edward German</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD GERMAN MD		22e. ADDRESS NH BLDG 10/RM 12N226 BETHESDA MD 20812					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/16/1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR PARK		23d. LOCATION CITY OR TOWN COUNTY STATE WESTWOOD, BERGEN, NEW JERSEY	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this page to the Division of Vital Records. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

041347 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02935
REG. NO.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Tina Marie Underwood										MONTH DAY YEAR 1/ 13/ 1987		M 10:00 a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 14 68		6. AGE (IN YEARS) MONTHS DAYS HOURS MIN. 18 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/ 13/ 1987		2d. HOUR a			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Mitchellville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2005 Mitchellville Rd.				12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) Assistant Aide		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Underwood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyne Scarbrough				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 216-02-9141				17. INFORMANT (Father) James Underwood				17. ADDRESS 504 Crestwood Drive Alexandria, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ligature and Manual Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1/ 13/ 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject strangled					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) basement				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2005 Mitchellville Rd., Pr. Georges Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1/14/87					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 01/17/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Anderson-Pendall					

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

JAN 19 1987

100% COTTON FIVE

Wichita Falls, Texas



100% COTTON FIVE

Wichita Falls, Texas

Item # 16b, Film G 624, 2/4/87 ra

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02930
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS E. P. UNTI			2a. DATE OF DEATH MONTH DAY YEAR 1-13-87		2b. HOUR 4:00 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 3 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSP.			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Ft. Wash.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Peter Unti		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Monida Evans				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 517-537-16-5522		17. INFORMANT ADDRESS Verna E. Unti as in item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 1-11 , 19 87 , to 1-13 , 19 87 , that (I) (we) lost saw the deceased alive on 1-12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE William Kent Junt MD				DEGREE MD		22c. DATE SIGNED 1/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Junt				22e. ADDRESS 11701 LIVINGSTON RD FT. WASH MD. 20744		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-15-87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, MD				25a. DATE REC'D. BY REGISTRAR JAN 27 1987		
25b. REGISTRAR'S SIGNATURE Julia Dwyer-Randall						

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

041020 JAN 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02931
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERNEST A. VALADE			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1987		2b. HOUR 9:04 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor N. H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY University	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4922 La Salle Rd. 20782	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Valade		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Bassett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 578-20-1697	17. INFORMANT ADDRESS Hilary Costello 6900 WI Ave. Chevy Chase, MD 20815			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980 to 1/8 , 19 87 , that (I) (we) lost saw the deceased alive on Jan 2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven F. Osborne, MD		DEGREE MD		22c. DATE SIGNED 1/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven F. Osborne		22e. ADDRESS 2737 Devonshire Place NW Wash DC 20008			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/12/87	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 3130 WI Ave. NW Wash., DC			25a. DATE REC'D. BY REGISTRAR JAN 14 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

041020140



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 02938

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OMER William VANSKOY, Jr.			2a. DATE OF DEATH MONTH DAY YEAR JAN 14 1987		2b. HOUR 9:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 2, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Marbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcom Grow Air Force Base Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hosp. Guard Ret.	12b. KIND OF BUSINESS OR INDUSTRY N.O.S.	
14. FATHER'S NAME FIRST MIDDLE LAST Omer William Vanscoy, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Hilemon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11, Korea 236-20-4319		17. INFORMANT ADDRESS Elizabeth Vanscoy-Daughter #13 as	
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from <u>14 Jan 87</u> to <u>14 Jan 87</u> , that (we) last saw the deceased alive on <u>14 Jan 87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. Reed Jaussi, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>14 Jan. 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REED JAUSSI</u>		22e. ADDRESS <u>Malcom Grow USAF MC</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/17/87	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery, Cheltenham, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Arenhart Funeral Home, Inc, La Plata, Md.		25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE <u>Julia K. Baker</u>	

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Item # 8,10,5 Film G 623, 1/21/87 I.J.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02939
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marie Anna VESELY			2a. DATE OF DEATH January 17, 1987		2b. HOUR 6:50 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH July 4, 1898 JANUARY 17, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) BALTIMORE MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.	
10. CITY OR TOWN OF DEATH LANHAM Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEORGE 13c. CITY OR TOWN GREENBELT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 119 PERTWINKLE COURT 20770	
14. FATHER'S NAME FIRST Henry MIDDLE Weger LAST		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Loeffler LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 212 07 7910	17. INFORMANT ADDRESS RAYMOND FLORENCE 3604 NORTHWAY DRIVE 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> 19 <u>87</u> , to <u>1/17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. S. Sadeghian</u>		DEGREE		22c. DATE SIGNED 1/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRADJ SADEGHIAN		22e. ADDRESS Doctors Hospital Lanham, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/21/1987	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS DIPPEL FUNERAL HOME 7110 BELAIR RD. BALTO. MD.		25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE <u>Lin. F. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JAN 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02940
REG. NO.

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Helen VRINOCK			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12 1987		2b. HOUR 3:05P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 1 1909		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince Georges	13c. CITY OR TOWN Glenn Dale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9905 Marguerita Avenue 20769
14. FATHER'S NAME FIRST MIDDLE LAST Michael Novotny			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Sholtis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 196-26-8537		17. INFORMANT ADDRESS Dorothy Eloshway daughter same as #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

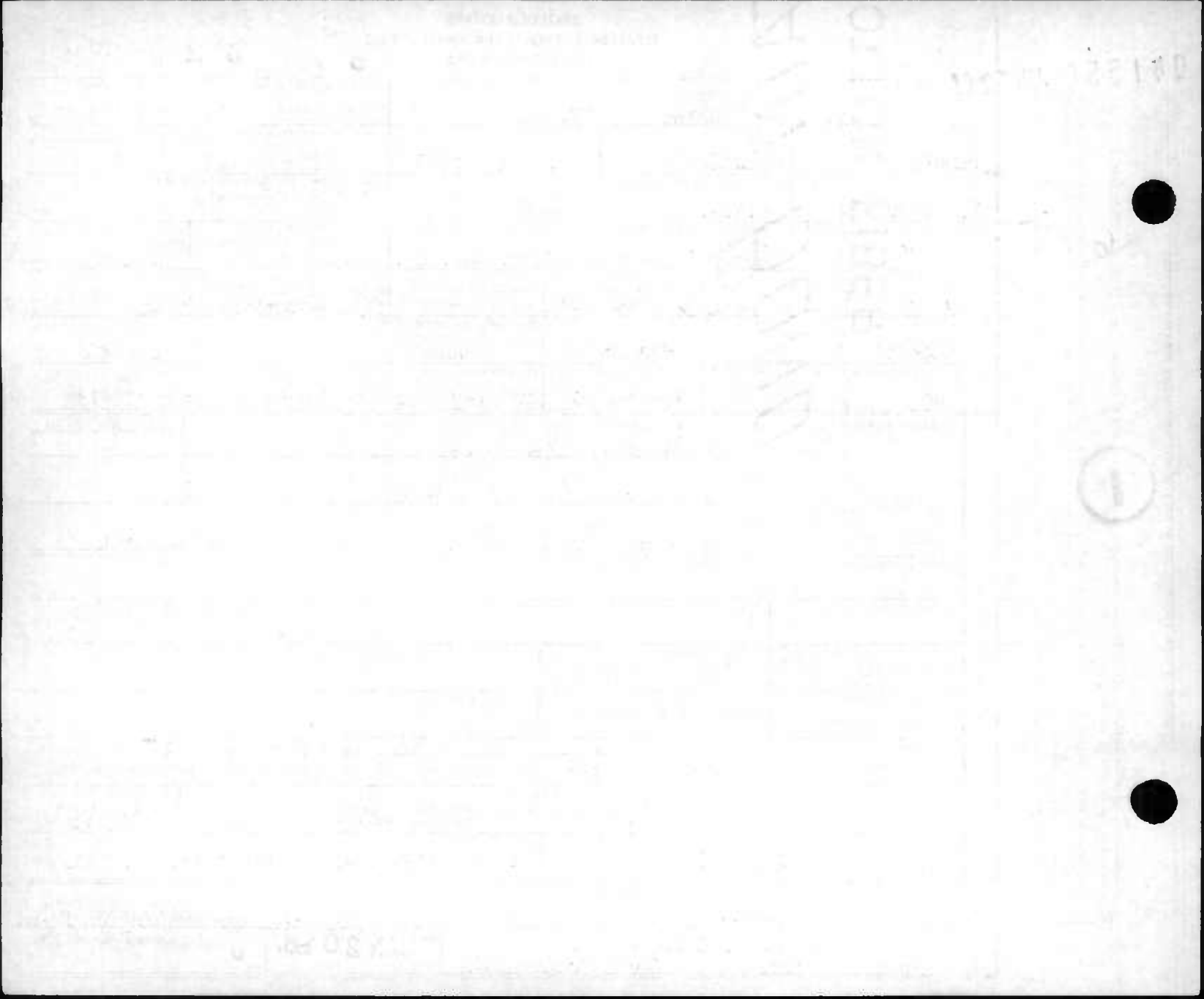
DUE TO, OR AS A CONSEQUENCE OF

(b) severe diarrhea - renal failure - Assoc. Infected
(c) emboli to all bowels and lower extremities

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to 11/2 19 87, that (I) (we) last saw the deceased alive on 11/2 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert Gereige A.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT GEREIGE, M.D.		22e. ADDRESS 4410 - 74th Ave., Hyattsville, Md. 20784	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 17, 1987	23c. NAME OF CEMETERY OR CREMATORY Fredericktown Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Fredericktown Washington Penn.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D BY REGISTRAR JAN 20 1987	



12-1-1913

Bank check to \$200.00
to the order of

Bank of America
No. 123456789

Pay to the order of
\$200.00
Twenty hundred and 00/100
Dollars



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No. 123456789

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **02942**

1. FOR STATE REGISTRAR		DECEASED NAME <small>(TYPE OR PRINT)</small> BENNIE A. WALKER		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-12-87 ₁₉		2b. HOUR M 12:50a	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JAN 17, 1968	6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 1-12-87 ₁₉	2d. HOUR 12:50a
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN CLINTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5313 TRENT STREET 20735		
14. FATHER'S NAME FIRST MIDDLE LAST BENNIE LEE WALKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE HINTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577 98 7153		17. INFORMANT MOTHER ADDRESS GRACE JONES - 5313 TRENT ST CLINTON MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. DATE OF INJURY HOUR A.M. MONTH DAY YEAR 3:45p 1-11-87 ₁₉		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in an auto/auto(s) collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Central Ave. & Ritchie Rd. Capitol Hgts., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		DATE (SPECIFY) 1-13-87 Assistant MEDICAL EXAMINER				DATE SIGNED 1-13-87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-15-87	23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG MD		
24. FUNERAL DIRECTOR NAME ALEXANDER POPE		ADDRESS 2617 PA AVE SE WASH DC		25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE <i>John Division</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM, PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
1- STATE per med exam
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
Mary			A.			Walter			DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1 5 19 87		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Female	White	9 16 1919	67 YRS.	MONTHS	DAYS	1 5 19 87			12:36		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
New York			U.S.A.						Prince George's County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton			Southern Maryland Hospital Center			Housewife					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Prince George's			Brandywine			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS					
Leo			Clinton, Sr.			Mary			Kline		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			083-160-4427			Robert W. Walter, 9403 Cheltenham Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Drug (Desipramine) intoxication											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Depressive disorder											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
Depressive reaction											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR			Subject ingested prescription medication.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
			home			9403 Cheltenham Dr., Brandywine, Prince Georges MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
1-5-87											
Re-issued											
DATE SIGNED 8-31-87											
ACTUAL SIGNATURE											
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.											
ADDRESS 111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			1-8-87			St. Charles Cemetery			Gardiner		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS			AUG 31 1987			Julia Davidson-Randall					
G.P. Kalas F.H. 6160 Oxon Hill Rd., Oxon Hill, MD											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JAMES E. WASHINGTON				1-28-87				10:57 A	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Black	MONTH DAY YEAR 01 20 1906		81		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Prince George MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly	Prince George Hospital			Guard		Govt.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Prince George		Bladensburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5999 Emerson St 20710	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
James Lorenzo Washington		Stella Queen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT ADDRESS					
No		N/A		578 07 4866 Vencil Gray 11310 Chantilly Lane Mitchellville Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC RENAL FAILURE</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-1987</u> to <u>1-28-1987</u> , that (I) (we) lost saw the deceased alive on <u>1-27-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>K. JOSEPH MATHEW</u>		MD				1/28/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>K. JOSEPH MATHEW</u>		<u>6511 KENILWORTH AVENUE RIVERDALE, MD 20737</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		2 Feb 87		Ft. Lincoln		Suitland		Pg Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.B. Jenkins FH 7474 Landover Rd Landover, Md.				JAN 30 1987		<u>Julia Davidson-Randall</u>			

2025 CO-110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
7. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED IRENE MIDDLE WASSMANN LAST						20. DATE OF DEATH MONTH DAY YEAR Jan. 6 1987		2b. HOUR 6:06 pm	
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR March 30 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Drs. Hospital of P.G. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY P.G. Co. Health Dept.	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9520 Lanham Severn Rd. 20706	
14. FATHER'S NAME FIRST George MIDDLE A. LAST Lake				15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE J. LAST Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-12-4301		17. INFORMANT ADDRESS 9520 Lanham Severn Rd. Seabrook, Md. 20706					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RECENT MYOCARDIAL INFARCTION</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive Heart Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/8/86 to 6 Jan 1987, that (we) lost saw the deceased alive on 31 Dec 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE OF PHYSICIAN Michael Schwartz		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/7/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHWARTZ		22e. ADDRESS 7500 Handover Pkwy #03, Greenbelt MD 20770							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Jan 9, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendon			
9013 Annapolis Rd. Lanham, Md. 20706									

GO:10

SECRET

SECRET

100-2304

[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 0 2 7 4 0

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)
LUTTERLOH

FIRST

MIDDLE

LAST

S.

WATKINS

2a. DATE OF DEATH MONTH DAY YEAR
01-10-87

2b. HOUR

2 45AM

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

06

13

1913

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

10. CITY OR TOWN OF DEATH

Cheverly

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Prince George Nursing Home

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

N/A

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

PG

13c. CITY OR TOWN

Upper Marlboro

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

125 Queen Ann Bridge Rd. 20772

14. FATHER'S NAME

William

MIDDLE

LAST

Montgomery

15. MOTHER'S MAIDEN NAME

FIRST

Lizzie

MIDDLE

LAST

Whitley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

N/A

16c. SOCIAL SECURITY NO.

246 54 1744

17. INFORMANT

Harry Watkins 125 Queen Ann Bridge Rd. Upper Marlboro, Md 20772

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

1. Coronary artery disease 2. Hypertension 3. Hyponatremia 4. Polio (stroke with left leg plegia)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

70a. AUTOPSY?

YES ☐ NO ☒

70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐

OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from NOV 22, 19 85, to Jan 10, 19 87, that (we) last

saw the deceased alive on Jan 10, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c. DATE SIGNED

Jan 10 '87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. HSL HUNG M.D.

22e. ADDRESS

3450 Fort Meade Rd #207 Laurel MD 20707

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

15 Jan 1987

23c. NAME OF CEMETERY OR CREMATORY

Resurrection

23d. LOCATION

CITY OR TOWN

Clinton

COUNTY

PG

Maryland

24. FUNERAL DIRECTOR

NAME

J.B. Jenkins FH 7474 Landover Rd Landover, Md

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JAN 21 1987

25b. REGISTRAR'S SIGNATURE

J. B. Jenkins

100-100000-100000



100-100000-100000

042625 FEB-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02941

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD M. WEEMS			2a. DATE OF DEATH MONTH DAY YEAR 01 11 87		2b. HOUR 4:25A M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 03 30 13	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.			13b. COUNTY P.G.	13c. CITY OR TOWN Landover	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Moses Weems			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-30-2436	17. INFORMANT ADDRESS 6419 Landover Rd., Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Gunfire</u> DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> 19 <u>86</u> to <u>1-14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>S. C. GUPTA</u>		22c. DATE SIGNED 1/12/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. C. GUPTA, M.D.	
22e. ADDRESS Prince George's Gen. Hosp. Md.		22f. DATE SIGNED 1/12/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 1/17/87	23c. NAME OF CEMETERY OR CREMATORY HARMONY MEN. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G. MD.	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS		24b. ADDRESS 4925 BURROUGHS AVE. N.E.		25a. DATE REC'D. BY REGISTRAR'S SIGNATURE JAN 30 1987	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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042209 JAN 29

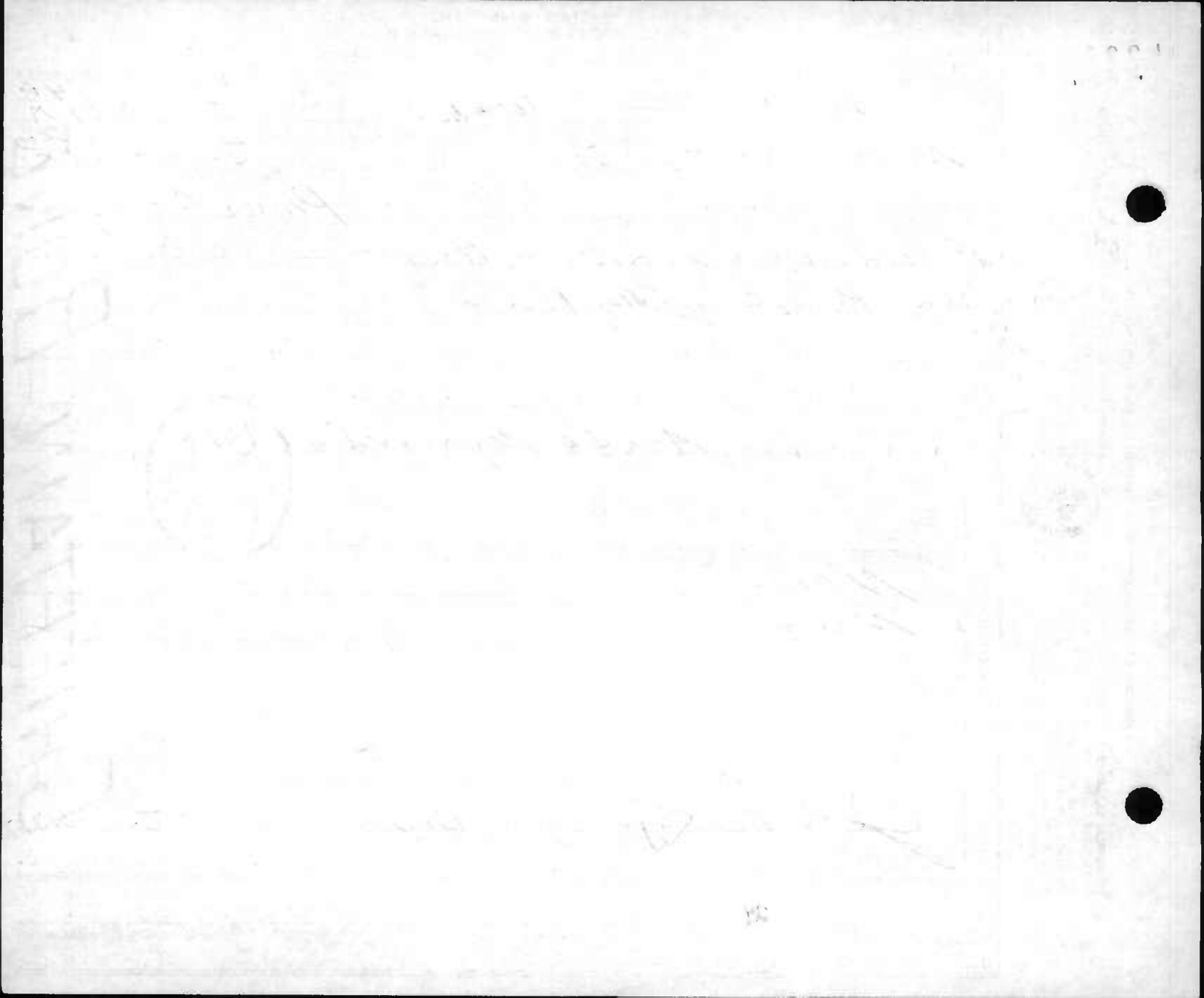
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCL. ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02948
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH PETER WEISS		20. DATE KNOWN OF DEATH ESTIMATED Jan 28 1987		21. HOUR 5:00	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Oct. 5, 1928	6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Jan 28 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Riversdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leeland Mem. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production Analyst	
13a. STATE Md		13b. COUNTY Prince George's		13c. CITY OR TOWN College Park	
14. FATHER'S NAME FIRST MIDDLE LAST UNAVAILABLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna L. Weiss		12b. KIND OF BUSINESS OR INDUSTRY Electronics	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 199-22-7801		17. INFORMANT ADDRESS Mrs. Mary T. Weiss, Same as Line #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep.		DATE SIGNED Jan 20 1987	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS 1919 Seminary Rd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-24-87	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.	
FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 28 1987	



042754 FEB-1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the other parties to the funeral and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body. **IMPORTANT:** If item 21 is marked "18" shows any injury, or other traumatic event, the medical examiner must be notified at once.

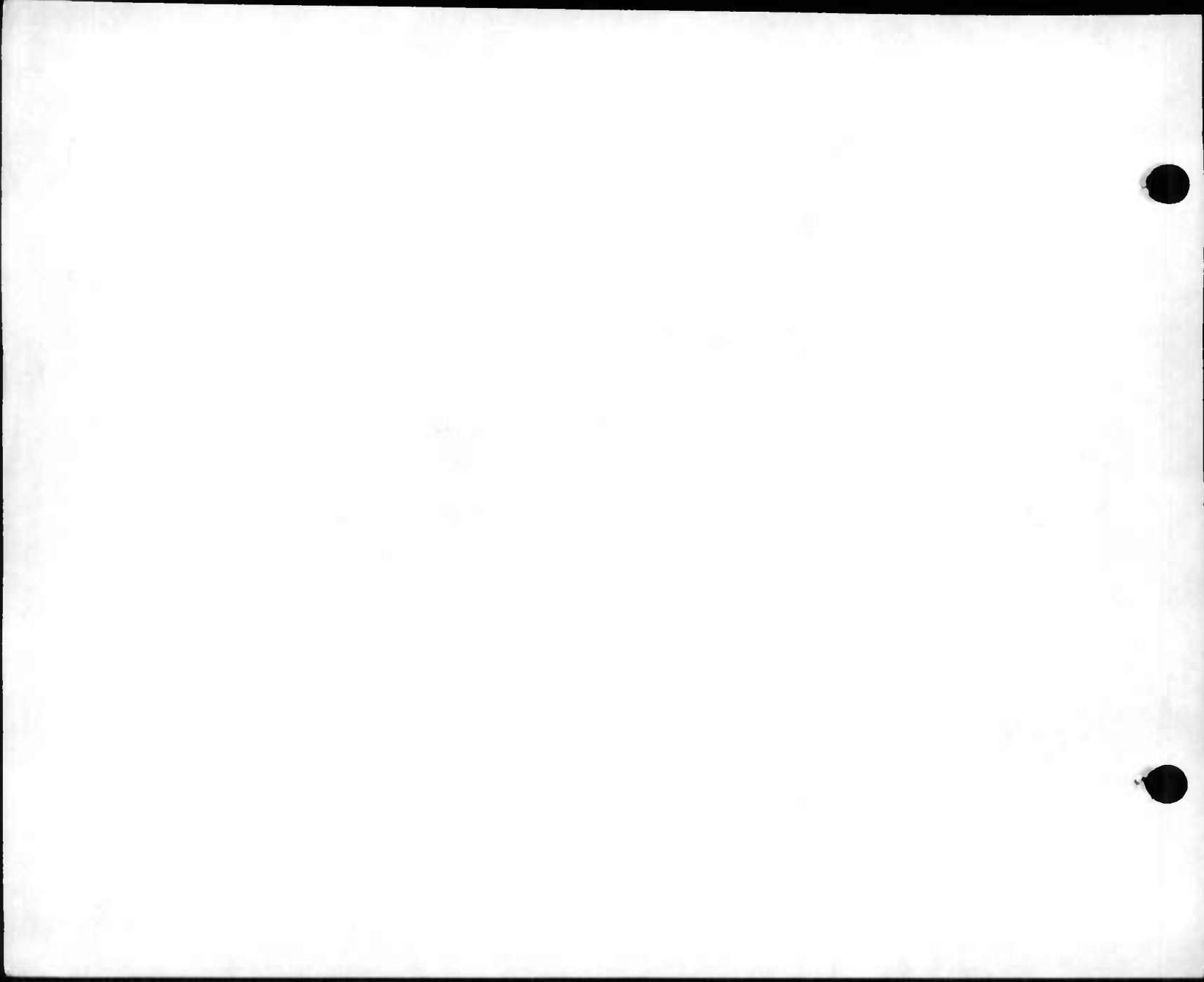
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		1/30/87		8:35A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		Black		May 15 1895		(91 YRS)		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Prince Georges		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Adelphi		Presidential Woods Health Ctr.		Clerk		Grocery Store			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Pr. Georges		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		1801 Metzert Rd., 20783	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Henry		Bowler		Adelaide		Robinson		4425 13th Pl. N.E. Washington, D.C. 20017	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Acute Cardiopulmonary Arrest		ASCVD		CHF		1/30/87	
								1980	
								1980	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CAD, Permanent Pacemaker, Senile Dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
No		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from 1/28/87 to 1/30/87, that (2) the deceased was alive on above date and (3) I did not view the body after death.		19		19		19		19	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
GB Patrick III MD						1/30/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY		22h. STATE	
GB Patrick III MD		9221 Colesville Rd Silver Spring, Md 20910		Manassas				Va.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY	
Burial		Feb. 4, 1987		Rose Hill		Manassas			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
Resard O. Adams		3914 QUARRY MANASSAS, VA.		FEB 2 1987		Julia D. Adams			

VOIDED DEATH CERTIFICATE NUMBER

87-02950

See 1986 deaths for Cynthia Lee Westbury



040983 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

02951

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Patricia Ann Weston			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1987		2b. HOUR 12:15A.M.		
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28 1932		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Prince-Geo.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilda Ernest Little		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Mae Emanuel		13e. STREET ADDRESS / ZIP CODE 4708 Lincoln Ave. 20705			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-24-7088		17. INFORMANT ADDRESS Leo Weston same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Terminal Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prostate Adenocarcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>9 days</u> <u>49 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO-MANUS AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, GARM., ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (myself) attended the deceased from <u>1/7</u> 19 <u>87</u> , to <u>1/8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Dennis R. Schumacher MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dennis R. Schumacher MD</u>		22e. ADDRESS <u>14201 Laurel Park Drive #102 Laurel MD 20707</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/87		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION BRENTWOOD PG Md.	
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME, INC. LAUREL, MD		24b. DATE REC'D. BY REGISTRAR JAN 16 1987		24c. REGISTRAR'S SIGNATURE <u>Julia Seiden-Rudnick</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These places on page 3 have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21, then any injury or other traumatic event, the medical examiner must be notified.

BP

040707 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 2 9 5 2

REG. NO.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div> <div> <div>1. STATE REGISTER</div> <div>1. DECEASED NAME (TYPE OR PRINT)</div> </div> <div> <div>2a. DATE OF DEATH MONTH DAY YEAR</div> <div>2b. HOUR</div> </div> </div>									
<div> <div> <div>3. SEX</div> <div>4. RACE</div> </div> <div> <div>5. DATE OF BIRTH MONTH DAY YEAR</div> <div>6. AGE (IN YEARS LAST BIRTHDAY)</div> </div> </div>									
<div> <div> <div>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> </div> <div> <div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>9. BALTIMORE CITY OR COUNTY OF DEATH</div> </div> </div>									
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</div> </div>									
<div> <div>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> </div>									
<div> <div>13a. STATE</div> <div>13b. COUNTY</div> <div>13c. CITY OR TOWN</div> <div>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div>13e. STREET ADDRESS / ZIP CODE</div> </div>									
<div> <div>14. FATHER'S NAME FIRST MIDDLE LAST</div> <div>15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST</div> </div>									
<div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)</div> <div>16b. SOCIAL SECURITY NO.</div> <div>17. INFORMANT (Daughter)</div> </div>									
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</div> <div> <div>18a. IMMEDIATE CAUSE (a)</div> <div>18b. DUE TO, OR AS A CONSEQUENCE OF (b)</div> <div>18c. DUE TO, OR AS A CONSEQUENCE OF (c)</div> </div> </div>									
<div> <div>19a. DATE OF OPERATION</div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> <div>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div>									
<div> <div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)</div> <div>21b. TIME OF INJURY HOUR (A.M. P.M.) MONTH DAY YEAR</div> <div>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)</div> </div>									
<div> <div>21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></div> <div>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</div> <div>21f. LOCATION STREET CITY OR TOWN COUNTY STATE</div> </div>									
<div> <div>22a. I certify that (I) (the hospital) attended the deceased from 1-1-87 to 1-1-87, that (I) (the hospital) saw the deceased alive on 1-1-87, and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did) (did not) view the body after death.</div> <div>22b. SIGNATURE DEGREE</div> <div>22c. DATE SIGNED</div> </div>									
<div> <div>22d. PHYSICIAN'S NAME (TYPE OR PRINT)</div> <div>22e. ADDRESS</div> </div>									
<div> <div>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</div> <div>23b. DATE</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>23d. LOCATION CITY OR TOWN COUNTY STATE</div> </div>									
<div> <div>24. FUNERAL DIRECTOR'S NAME ADDRESS</div> <div>25a. DATE REC'D. BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> </div>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page may be carbon papered. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene in order to bury, cremate, or remove.

IMPORTANT: If marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint handwritten text, possibly bleed-through from the reverse side.]

041803

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

999999
07-8
25M
DHMH: 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
REG. NO. 02953										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE KNOWN OF DEATH					2b. HOUR
Angela Maria Wilkerson					DATE ESTI MATED <input checked="" type="checkbox"/> 1/10/ 1987					M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	Black	03 9 1965	21 YRS.	MONTHS	DAYS	1/13/ 1987		1:00 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		United States				Prince George's County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Suitland		wooded area Whitehall St.				none		none		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
D.C.				Washington				2412 Hartford St. S. E. 111		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Leon Wilkerson					Mary String fellow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		LANDOVER MD.		
No		None		577-98-3882		Leon Wilkerson 6814 W Forrest Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Multiple Stab Wounds										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR		subject stabbed						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
		wooded area		Whitehall Street, Suitland, Pr. Geo. Co., Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED				
Gregory R. Kauffman, M.D.		Assistant MEDICAL EXAMINER				1/14/87				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS				111 Penn St.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE		
Burial		1-20-87		Harmony Cemetery		Landover		P.G. Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Comer-Hodges		4901 Marlboro PK. Coral Hills, Md.		JAN 23 1987		Julia Davidson Landover				

MINITIA

NOTION 2103

14

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02954

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE Anne WILLER			2a. DATE OF DEATH MONTH DAY YEAR 01 16 87		2b. HOUR 10 05 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 24, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3702 Ivy Hill Lane 20715
14. FATHER'S NAME FIRST MIDDLE LAST Wiley M. Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy M. Bowen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 257-16-6337		17. INFORMANT ADDRESS Russell T. Willer same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Fulminant Pancreatitis DUE TO, OR AS A CONSEQUENCE OF (c) Status Post Splenectomy, recent					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cirrhosis of Liver with Portal Hypertension Bleeding Esophageal Varices					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ADDRESS		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1986, to 1-16, 1987, that (I) (we) last saw the deceased alive on 1-16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Arora		DEGREE MD		22c. DATE SIGNED 1/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rakesh Arora MD		22e. ADDRESS 14300 Gallant Fox Lane, Bowie, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 21 1987	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25. DATE REC'D. BY REGISTRAR JAN 28 1987	
26. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

MEDICAL CERTIFICATION

49

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02955
REG. NO.

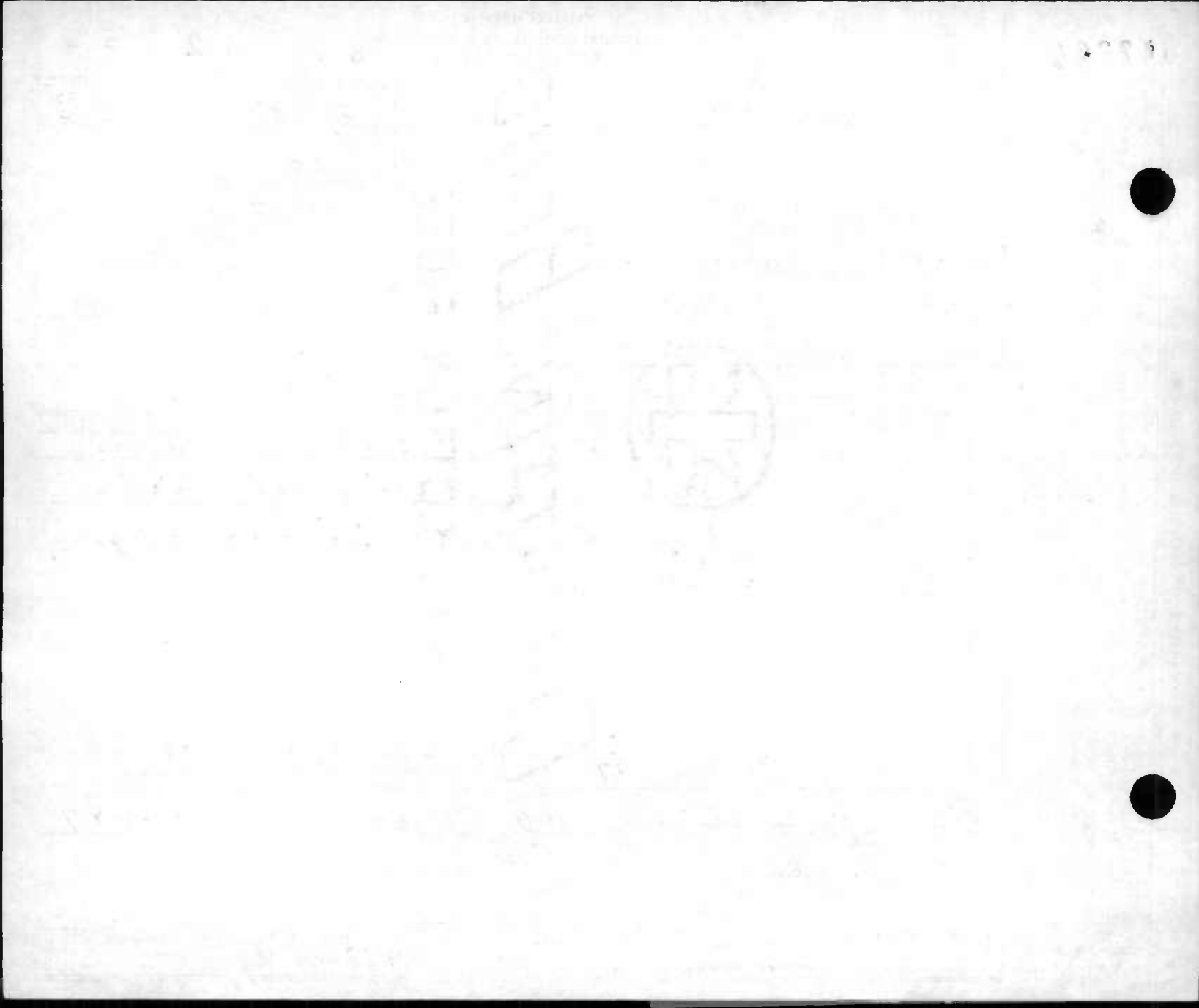
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Dudley LAST Williams			2a. DATE OF DEATH MONTH DAY YEAR 1-21-87		2b. HOUR 5:35 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 30 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nsg Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Henry MIDDLE Benjamin LAST Williams		15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE W.F. LAST Brown		13e. STREET ADDRESS / ZIP CODE 6432 Otis Street 20784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-38-1114		17. INFORMANT 410 V.M.I. ADDRESS Parade, John W. Knapp, Lexington, Va. 24450			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Pneumonia, left Lower Lobe DUE TO, OR AS A CONSEQUENCE OF, (c) Upper Respiratory Infection. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 48 hrs 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Heart Disease.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1959 to 20 January 1987, that (I) (we) lost saw the deceased alive on 20 Jan 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas M. Hutchins		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas M. Hutchins		22e. ADDRESS 6214 Landover Road, Landover, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-26-87		23c. NAME OF CEMETERY OR CREMATORY Vauters Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Loretta, Essex, Va.	
24. FUNERAL DIRECTOR NAME FRANCIS CASCH'S SONS FUNERAL HOME, P.A. ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpapers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



042831 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02950
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Philetas (N.M.I.) Williams, Sr.										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1-23-87		2b. HOUR	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05/01/05	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-23-87	7d. HOUR	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building Supervisor Board of Education			12b. KIND OF BUSINESS OR INDUSTRY				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE, GIVE STREET ADDRESS) Doctors Hospital				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7B Couthway Road 20770				
14. FATHER'S NAME FIRST MIDDLE LAST William Jackson Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie C. Thacker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-32-3100		17. INFORMANT ADDRESS Rita M. Williams (Wife) Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE Sudden pulmonary cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED 1-23-87					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 01/25/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
25a. DATE REC'D. BY REGISTRAR FEB 3 1987				25b. REGISTRAR'S SIGNATURE John P. ...									
25c. REGISTRAR'S NAME Francis G. ...													
25d. REGISTRAR'S ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781													

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

10-11-1914

Photostat made by

1-22-1

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10-22-1

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10-22-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02951

REG. NO.

1. DECEASED NAME (Type or print) A GORDON		FIRST MIDDLE LAST WILLOUGHBY		2a. DATE OF DEATH MONTH DAY YEAR 1 18 87		2b. HOUR M 1:13 P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 15 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. Maryland Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY US Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3059 Brinkley Road 20748		14. FATHER'S NAME FIRST MIDDLE LAST Dick Willoughby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Alspaugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 280 16 5634		17. INFORMANT ADDRESS Shirley P Willoughby Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Constrictive Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-16 19 87 to 1-18 19 87 , that (I) (we) lost saw the deceased alive on 1-18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. D.				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOTIL K. KOUL M.D.				22e. ADDRESS 3710 Riviera St, Temple Hills, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 Jan 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
				25b. REGISTRAR'S SIGNATURE Julia B. ...			

BP

01-01-10

10-1-10

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042618 FEB-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02958
REG. NO.

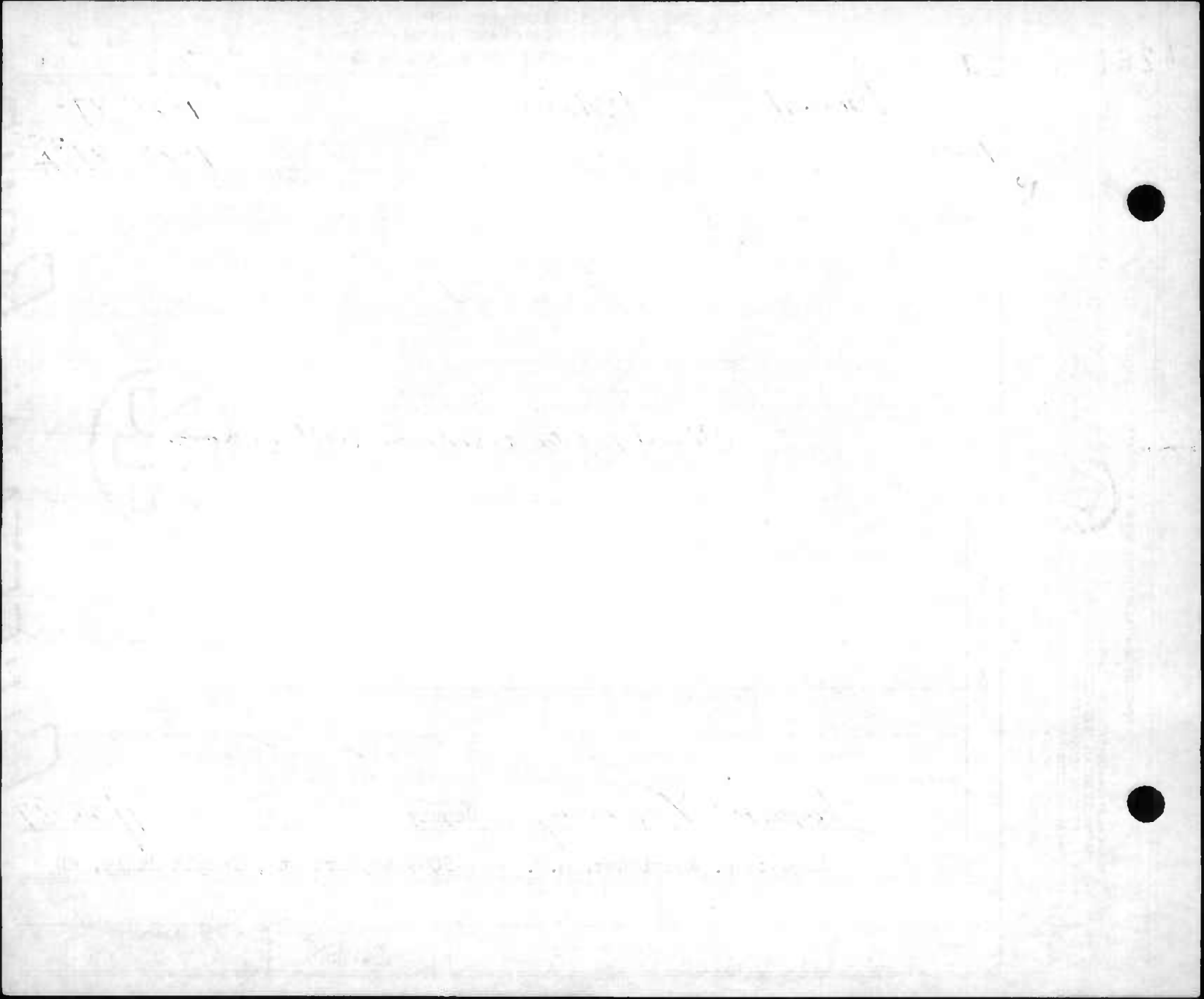
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Darnell</i>		MIDDLE <i>Wilson</i>		LAST <i>Wilson</i>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>1-28-87</i>		7b. HOUR M <i>2:55</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-20-36</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>50 YRS.</i>		IF UNDER 1 YR MONTHS DAYS <i>50 YRS.</i>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>1-28-87</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Project Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George Hosp</i>		12c. STREET ADDRESS <i>6812 Valley Park Road</i>		13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince Geo.</i>		13c. CITY OR TOWN <i>Capitol Hts</i>	
14. FATHER'S NAME FIRST <i>Phillip</i>		MIDDLE <i>Wilson</i>		LAST <i>Violet</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Diggs</i>		MIDDLE <i>Diggs</i>		LAST <i>Diggs</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>7/26/54-1/58 214327594</i>		17. INFORMANT <i>Magaret E. Wilson</i>		ADDRESS <i>6812 Valley PK Capitol Ht MD</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Ethanol hepatic cirrhosis with anasarca</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	
23b. DATE <i>2-2-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cheltenham</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cheltenham PG MD</i>		24. FUNERAL DIRECTOR NAME <i>J.B. Jenkins</i>		ADDRESS <i>Funeral Hm Landover, Md</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1987</i>	
25b. REGISTRAR'S SIGNATURE <i>Augusto P. Rodriguez</i>		25c. DATE <i>1/28-87</i>		25d. REGISTRAR'S SIGNATURE <i>Augusto P. Rodriguez</i>		25e. DATE <i>1/28-87</i>		25f. REGISTRAR'S SIGNATURE <i>Augusto P. Rodriguez</i>		25g. DATE <i>1/28-87</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, WITH FORM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02959

REG. NO.

1. FOR
STATE
REGISTER

DECEASED NAME (TYPE OR PRINT) Rose C. Wisconsin		2a. DATE OF DEATH MONTH DAY YEAR 1 18 87		2b. HOUR 6:48 PM	
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 25 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Ctr.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Temple Hills	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Loreto		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Borello		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-88-4401		17. INFORMANT Ethel G. Williams ADDRESS 5707 Janice Lane Temple Hills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/27/86 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/18 87	
22a. I certify that (I) (this hospital) attended the deceased from 1/18 87 to 1/18 87 , that (I) (we) last saw the deceased alive on 1/18 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE John C. Patterson, M.D.		DEGREE Consulting ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Patterson M.D.		22e. ADDRESS 7501 Surratt Rd Clark Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/87		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cen.	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 21 1987	
				25b. REGISTRAR'S SIGNATURE John C. Patterson	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia					

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040655 JAN 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02960
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES EDWARD WISEMAN <i>Charles Edw. Wiseman</i>		2a. DATE OF DEATH MONTH DAY YEAR 1/6/87		2b. HOUR 1 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 10 88	
6. AGE (IN YEARS LAST BIRTHDAY) 58		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cable Slicer		12b. KIND OF BUSINESS OR INDUSTRY Pepco		13. STREET ADDRESS / ZIP CODE 3302 Otis Street 20712	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Wiseman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorthea Goldenstroth		16. SOCIAL SECURITY NO. 579-03-1481	
17. INFORMANT Durward Ryce, Seabrook, Md. 20706		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis heart disease (c) Nephrosclerosis & uremia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 4 yrs 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Alcoholism, pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 86 to JAN 6 87 that (I) (we) lost saw the deceased alive on JAN 6 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>T. Bergemann</i>		DEGREE M.D.		22c. DATE SIGNED 1-6-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Till Bergemann		22e. ADDRESS 115 Centerway, Greenbelt, Md. 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-9-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland		23e. NAME OF FUNERAL HOME FRANCIS CASCH'S SONS FUNERAL HOME, P.A.			
23f. ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland		24. DATE REC'D. BY REGISTRAR JAN 13 1987		25. REGISTRAR'S SIGNATURE <i>Julia Tindin-Buchanan</i>	

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040688 JAN 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the Division of Vital Records. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN G. WOHL									
2a. DATE OF DEATH MONTH DAY YEAR 01-02-87									
2b. HOUR 11 00PM									
3. SEX FEMALE									
4. RACE WHITE									
5. DATE OF BIRTH MONTH DAY YEAR JAN. 26, 1904									
6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY									
7b. CITIZEN OF WHAT COUNTRY? U.S.A.									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.									
10. CITY OR TOWN OF DEATH CHEVERLY									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE									
12b. KIND OF BUSINESS OR INDUSTRY RED CROSS									
13a. STATE Md.									
13b. COUNTY ANNE ARUNDEL									
13c. CITY OR TOWN BOWIE									
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET ADDRESS / ZIP CODE 2507 KAYHILL LA. 20715									
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE GROSSMAN									
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no									
16b. SOCIAL SECURITY NO. 458-34-9197A									
17. INFORMANT ADDRESS BEN FRIEDMAN (SAME AS ITEM #13)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 10, 1986</u> to <u>JAN 2, 1987</u> , that (I) (we) lost saw the deceased alive on <u>DEC 20, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.									
22b. SIGNATURE Norman K. Bottrere MD									
22c. DATE SIGNED JAN 5, 1987									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN K. BOTTRERE									
22e. ADDRESS 3231 SUPERIOR LANE BOWIE, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION									
23b. DATE 1-6-1987									
23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY									
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.									
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.									
24b. ADDRESS RIVERDALE, Md. 20737									
25a. DATE REC'D. BY REGISTRAR JAN 13 1987									
25b. REGISTRAR'S SIGNATURE Julia Davidson-Rubens									

BP _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

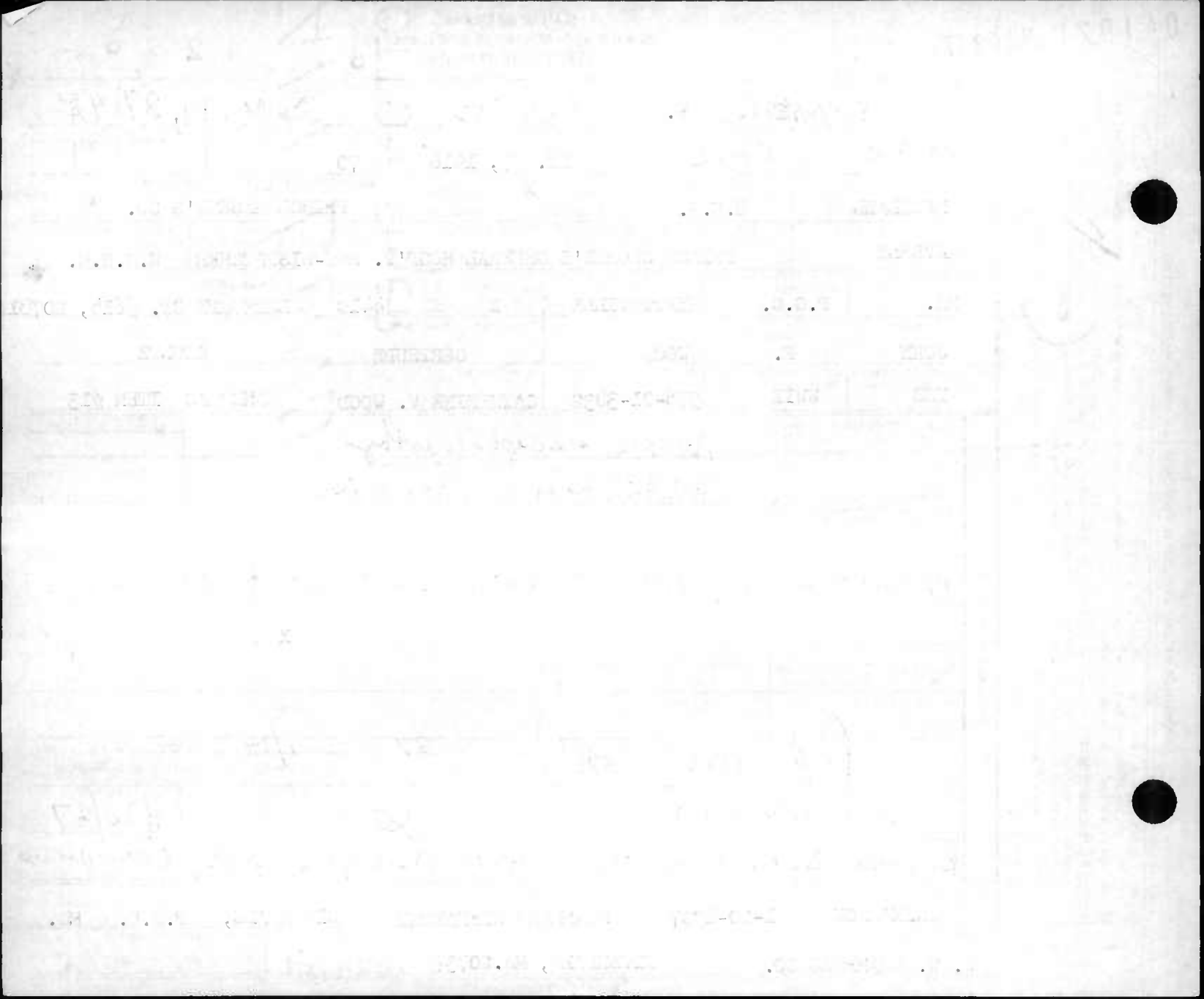
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02902

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kenneth E. Wood			2a. DATE OF DEATH MONTH DAY YEAR JAN. 19, 87			2b. HOUR 4:30 A.M.			
3. SEX Male		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR OCT. 7, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S CO. MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP'T.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET-DISPATCHER		12b. KIND OF BUSINESS OR INDUSTRY W.S.S.C.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY P.G.C.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. WOOD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE SHULTZ			13e. STREET ADDRESS / ZIP CODE 4410 OGLETHORPE ST. #614, 20781			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATE(S)) WWII		17. INFORMANT CATHERINE V. WOOD		ADDRESS SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANoxic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>BRAINSTEM INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pneumonia, Respiratory Failure, Chronic obstructive Pulm. Dis.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> 19 <u>87</u> to <u>1/19</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on above, (I) (we) (do) (did not) view the body after death.									
23a. SIGNATURE <u>Richard J. Feldman, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED 1/20/87	
24. PHYSICIAN'S NAME (TYPE OR PRINT) Richard J. Feldman, MD						25a. ADDRESS 9580 Annapolis Rd, CAMMAM, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 1-20-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE RIVERDALE, P.G.C. Md.		
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.						25b. DATE REC'D. BY REGISTRAR 25c. REGISTRAR'S SIGNATURE JAN 28 1987 Julia Davidson-Randall			

BP _____



040376 JAN 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH E WORTHY					2a. DATE OF DEATH MONTH DAY YEAR 01 05 87					2b. HOUR 2 00P M							
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 12 13		6. AGE (IN YEARS LAST BIRTHDAY) 73			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisa City, Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.											
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Unknown								
13a. STATE Md.		13b. COUNTY PRINCE GEORGE'S		13c. CITY OR TOWN Walldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3404 Accokeek Road 20601									
14. FATHER'S NAME FIRST MIDDLE LAST Jimmie Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Brown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-20-6460		17. INFORMANT ADDRESS Mr. Walter Worthy/husband/same as 13e													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRA CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMER'S DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PNEUMONIA PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 12/23 1986 to 1/5 1987, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE R. Arora		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. R. ARORA				22e. ADDRESS 14300 GALLANT FOX LANE #222, BOWIE, MD. 20715													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-9-87		23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION Brandywine, Md.		23e. COUNTY STATE									
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C. 20017						25a. DATE REC'D. BY REGISTRAR JAN 9 1987		25b. REGISTRAR'S SIGNATURE Julia...									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO. 02964									
1. DECEASED NAME (LAST, FIRST, MIDDLE) Willie Mae Wright			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1/30 1987			2b. HOUR 12:57 A.M.			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1890	6. AGE (IN YEARS) LAST BIRTHDAY 97 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/30 1987		2d. HOUR A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Moundsville, S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4000 - 36th Street, #204			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY None		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4000 - 36th Street, #204	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Terry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patsy Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-12-9555		17. INFORMANT ADDRESS Ms. Ozell Harden/sister/same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>generalized arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, MD		DATE SIGNED 1/30/87	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-30-87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.		
24. FUNERAL DIRECTOR NAME John T. Rhines Co.			ADDRESS 3015 12th St. N.E., D.C. 20017			25a. DATE REC'D BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE <i>John T. Rhines</i>	

07/84

25M

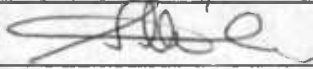

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(VR A15 ME (1))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 02955
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANCES C. YEUGELOWITZ			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 11, 1987			2b. HOUR P M 09:15				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 21 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6370 Euclid Ave. Balto. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Frankowitz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 112-20-7902	
17. INFORMANT ADDRESS Vincent Yeugelowitz 6370 Euclid Ave. Elkridge, Md. 21227			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis and Right lower lobe pneumonia 1 day DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral Cerebrovascular Accident 4 weeks			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 86 , to 1/11 , 19 87 , that (I) (we) lost saw the deceased alive on 1/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sadiq			22e. ADDRESS Greater Laurel Hospital Laurel, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-14-87		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Queens, New York			
24. FUNERAL DIRECTOR NAME ADDRESS Gary L. Kaufman Funeral Home 5695 Main St. Elkridge, Maryland 21227						25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please immediately return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

BP

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042297 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 02700

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dana Lynn Yost			2a. DATE OF DEATH MONTH DAY YEAR 01 14 87		2b. HOUR 8:17 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 14, 1961		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3356 Huntley Square Drive 20748
14. FATHER'S NAME FIRST MIDDLE LAST Robert A. Yost, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara L. Ballard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-78-3673		17. INFORMANT ADDRESS Barbara Strawn, Same as Line #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bleed Pneumonia - Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe tracheal secretions</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Quadruplexia Signs Disorde Head Injury</u>					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>1-14-87</u> to <u>1-14-87</u> , that (ii) we last saw the deceased alive on <u>1-14-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (iii) we (did) (did not) view the body after death.					
22b. SIGNATURE <u>G. Edgecombe MD</u>		DEGREE		22c. DATE SIGNED <u>1-15-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. Edgecombe MD</u>		22e. ADDRESS <u>7700 Old Branch Ave Clinton MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/17/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D BY REGISTRAR JAN 28 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

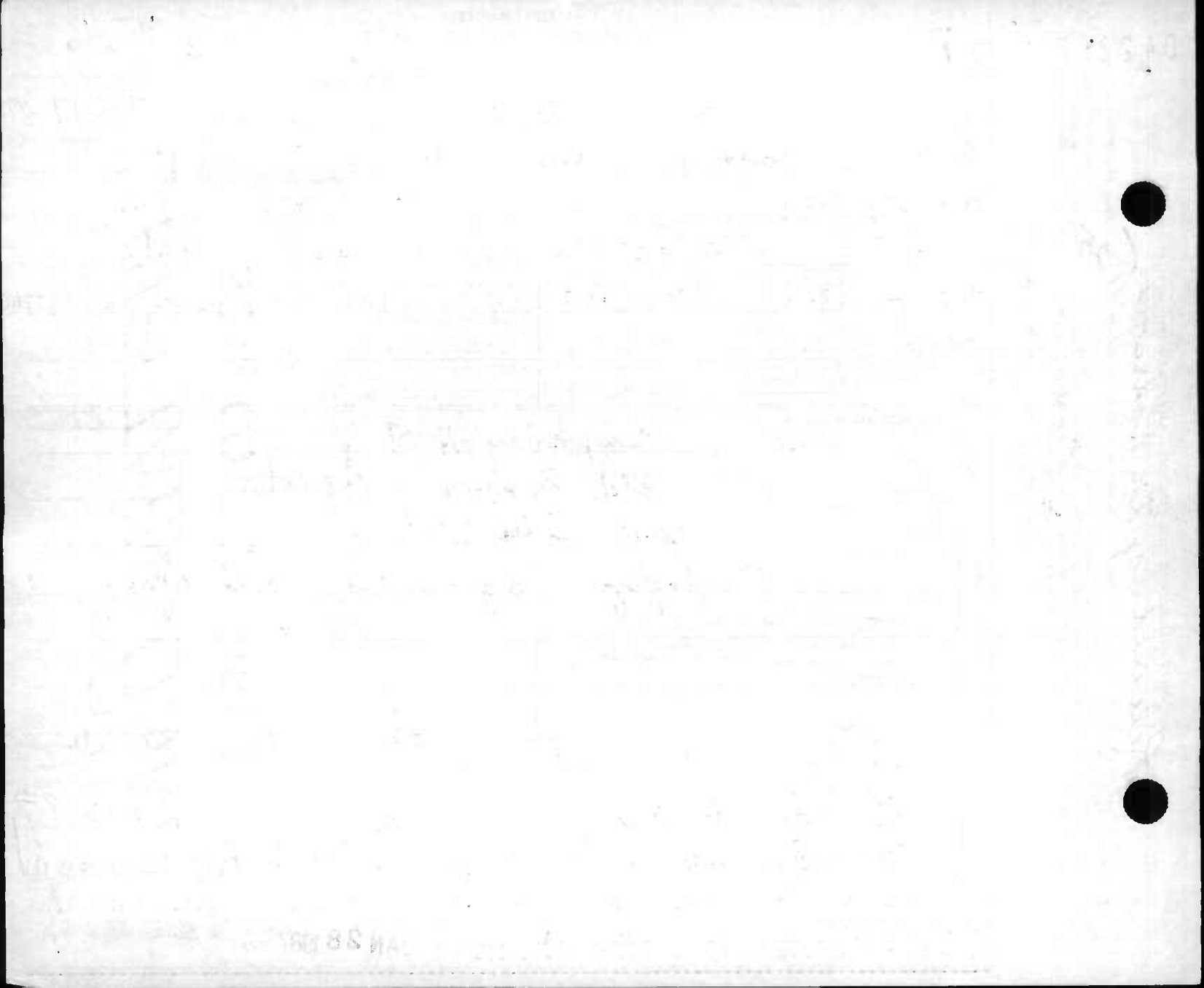
Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REC. NO. **02701**

1. STATE REGISTRAR FOR										2a. DATE KNOWN OF DEATH		MONTH DAY YEAR 1-26 1987		2b. HOUR 1:57 P.M.	
1. DECEASED NAME FIRST MIDDLE LAST FRANKLIN L. Young										2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 1-26 1987		2d. HOUR 1:57 P.M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jul 13, 1965		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3934 Suitland Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Suitland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3934 Suitland Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE District of Columbia				13b. CITY OR TOWN Washington				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 1800 Shepherd Street, N.E. #105			
14. FATHER'S NAME FIRST MIDDLE LAST David Young				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Williams				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 578 96 9741			
17. INFORMANT Gloria Young-mother-4130 Suitland Road, Apt. # 201, Suitland, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				19. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR ? P.M. 1-26 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) found in auto				21f. LOCATION CITY OR TOWN COUNTY STATE 3934 Suitland Road, Suitland, Prince George's Co., Maryland							
22a. I certify that I took charge of the remains described above, held an										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
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22a. I certify that I took charge of the remains described above, held an										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
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22a. I certify that I took charge of the remains described above, held an										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
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22a. I certify that I took charge of the remains described above, held an										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. I certify that I took charge of the remains described above, held an										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
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22a. I certify that I took charge of the remains described above, held an										Autopsy					

Handwritten notes and markings on the right margin, including a circled '1' and two punch holes.